

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10459

10368

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1621 Otis Street, N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elijah Middle Henry Last Allen, Jr.				4. DATE OF DEATH Month September Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10, 1903	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY Medical		13. FATHER'S NAME Elijah H. Allen, Sr.	
14. MOTHER'S MAIDEN NAME Emma Russell				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage from Esophageal Varices 581.0 DUE TO (b) Thrombosis of Portal Vein DUE TO (c) Post Necrotic Cirrhosis Interval between onset and death: days weeks months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 25, 1960 to September 20, 1960 , that (I) (we) lost saw the deceased alive on September 20, 1960 , and that death occurred at 8:00 PM from the causes and on the date stated above.							
22a. SIGNATURE Robert R. Carpenter, M.D.				22b. DATE SIGNED 9/21/60			
22c. PHYSICIAN'S NAME (Type) Robert R. Carpenter, M. D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 9/24/60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, (Suitland) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Plummer				25a. REC'D BY REGISTRAR SEP 26 '60		25b. REGISTRAR'S SIGNATURE Carlton S. Kline	

(1)

The following information was obtained from the records of the Department of the Interior, Bureau of Land Management, on the subject of the land owned by the United States in the State of California, and the same is being furnished to you for your information.

The land owned by the United States in the State of California is divided into two classes, namely, land owned by the United States in fee simple, and land owned by the United States in trust for the benefit of the Indians.

The land owned by the United States in fee simple is divided into two classes, namely, land owned by the United States in fee simple, and land owned by the United States in trust for the benefit of the Indians.

The land owned by the United States in trust for the benefit of the Indians is divided into two classes, namely, land owned by the United States in trust for the benefit of the Indians, and land owned by the United States in trust for the benefit of the Indians.

(1)

The following information was obtained from the records of the Department of the Interior, Bureau of Land Management, on the subject of the land owned by the United States in the State of California, and the same is being furnished to you for your information.

The land owned by the United States in the State of California is divided into two classes, namely, land owned by the United States in fee simple, and land owned by the United States in trust for the benefit of the Indians.

The land owned by the United States in fee simple is divided into two classes, namely, land owned by the United States in fee simple, and land owned by the United States in trust for the benefit of the Indians.

The land owned by the United States in trust for the benefit of the Indians is divided into two classes, namely, land owned by the United States in trust for the benefit of the Indians, and land owned by the United States in trust for the benefit of the Indians.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10412
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10369

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & HOSPITAL</u>		d. STREET ADDRESS <u>14 Sherman Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Hugo</u> Middle <u>Faust</u> Last <u>Ambrosi</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-93</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>29</u> Hours <u>18</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Examiner U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Faust A. Ambrosi</u>		14. MOTHER'S MAIDEN NAME <u>Amelia L. Lombardi</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(blank)</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>(blank)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> -DUE TO- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>with 3rd degree Pap. Circumang. Blockade</u> -DUE TO- <u>surgery</u> (c) <u>(blank)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>(blank)</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>9</u> Day <u>11</u> Year <u>1960</u> Hour <u>11</u> a.m. <u>39</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Baltimore</u> (County) <u>Harford</u> (State) <u>Md</u>
21. I certify that (I) (this hospital) attended the deceased from <u>9/11/60</u> to <u>9/29/60</u> , that (I) (we) last saw the deceased alive on <u>9/29/60</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard T. Morse</u>		22b. DATE SIGNED <u>9/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD T. MORSE</u>		22d. ADDRESS <u>7030 Carroll Ave. Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 3, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore Heights, Harford County, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Arthur Walters</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	
ADDRESS <u>254 Carroll St NW D.C.</u>		DATE <u>OCT 3 '60</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used for burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10460 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10370											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Monrovia d. STREET ADDRESS Rt. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Walter Edward Anderson						4. DATE OF DEATH Month Day Year September 4 19 60					
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1895		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deliveryman				10b. KIND OF BUSINESS OR INDUSTRY Ice		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Anderson						14. MOTHER'S MAIDEN NAME Bessie Washington					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) Yes W.W. # 1				16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Acute Congestive Heart Failure DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> 9-4-60 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart M.D.				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/60		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove ADDRESS Damascus, Md.				22d. LOCATION (City, town, or country) Purdim, Md. (State)			
23. FUNERAL DIRECTOR Olin L. W. Johnson				24a. REC'D BY REGISTRAR DATE SEP 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10371

10389

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN b 5 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8915 GEORGIA AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 29 SILVER SPRING d. STREET ADDRESS 8915 GEORGIA AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle KATHERINE Last ARENDS		4. DATE OF DEATH Month SEPTEMBER Day 29 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/22/82
9. AGE (In years last birthday) 78 Yrs.		IF UNDER 1 YEAR Months 7 Days 7	IF UNDER 24 HRS. Hours 7 Min. 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) SALEM, MICHIGAN
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE STAEB	
14. MOTHER'S MAIDEN NAME KATHERINE FINKBINER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Dr. Theodore G. Arends, 8915 Ga. Ave. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) sudden (c) History of previous heart disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) History of previous heart disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. no	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
DATE SIGNED 9/29/60		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 10/1/60		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND		23. FUNERAL DIRECTOR WARNER E. PIMPHREY, INC. Address SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

REPORT OF THE BOARD OF DIRECTORS

1900

THE BOARD OF DIRECTORS

OF THE

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

THE BOARD OF DIRECTORS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause in the space provided. To be filed in the office of the Medical Examiner or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

STATE OF MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10372

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6907 Maple Ave., Chevy Chase, Md.</u>		d. STREET ADDRESS <u>6907 Maple Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>H.</u> Last <u>Barnard</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/02</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elect. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Standards Wash., D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Montgomery Barnard</u>		14. MOTHER'S MAIDEN NAME <u>Grace Haliday</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>467-03-8795</u>	
17. INFORMANT <u>Dorothy W. Barnard-Item # 2</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		DATE SIGNED <u>9/29/60</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> <u>1331 E. Montgomery Ave. Rockville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 30 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10373

10461

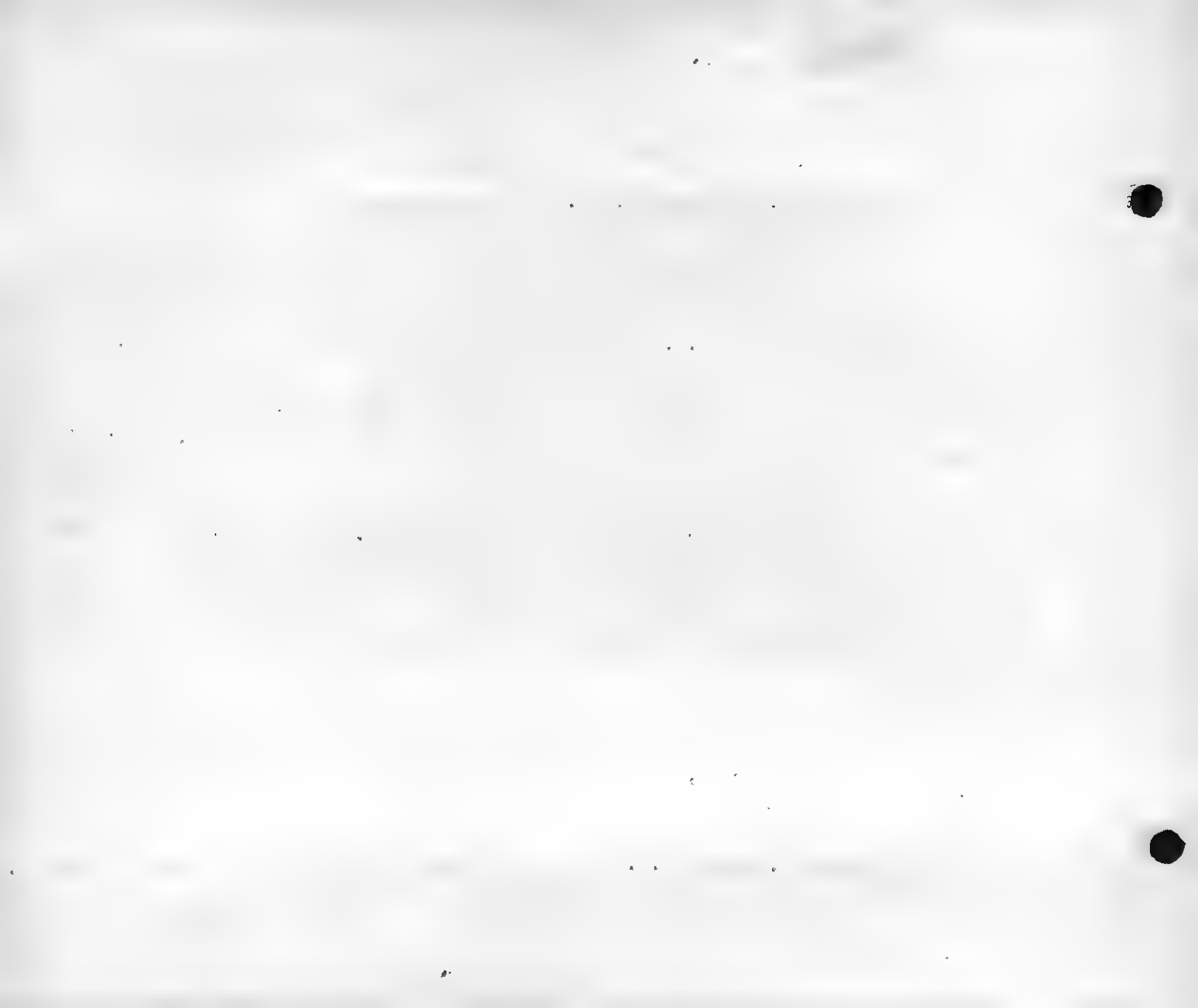
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 17 Pratt Street			
3. NAME OF DECEASED (Type or print) First Ralph Middle Elmer Last Bates				4. DATE OF DEATH Month September Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1894	9. AGE (n years last birthday) 66 yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ralph Bates				14. MOTHER'S MAIDEN NAME Ella Morrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary insufficiency DUE TO 162-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bronchogenic carcinoma with wide spread metastasis (c) Severe atherosclerosis of aorta and coronaries with old anterior wall infarct							INTERVAL BETWEEN ONSET AND DEATH 2 Days 1 Year 1 Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour _____ a. m. _____ p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from September 15, 1960 to September 15, 1960 , that (I) (we) last saw the deceased alive on September 15, 1960 , and that death occurred at 12 p. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Jerome B. Block</i>				22b. DATE September 16, 1960			
22c. PHYSICIAN'S NAME (Type) Jerome B. Block, M.D.				22d. ADDRESS The Clinical Center National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, OR DISPOSAL CREMATION		23b. DATE THEREOF 9/19/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City, town, or county) _____ (State) _____ Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee's Sons Co.				25a. REC'D BY REGISTRAR SEP 19 1960		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kneass</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

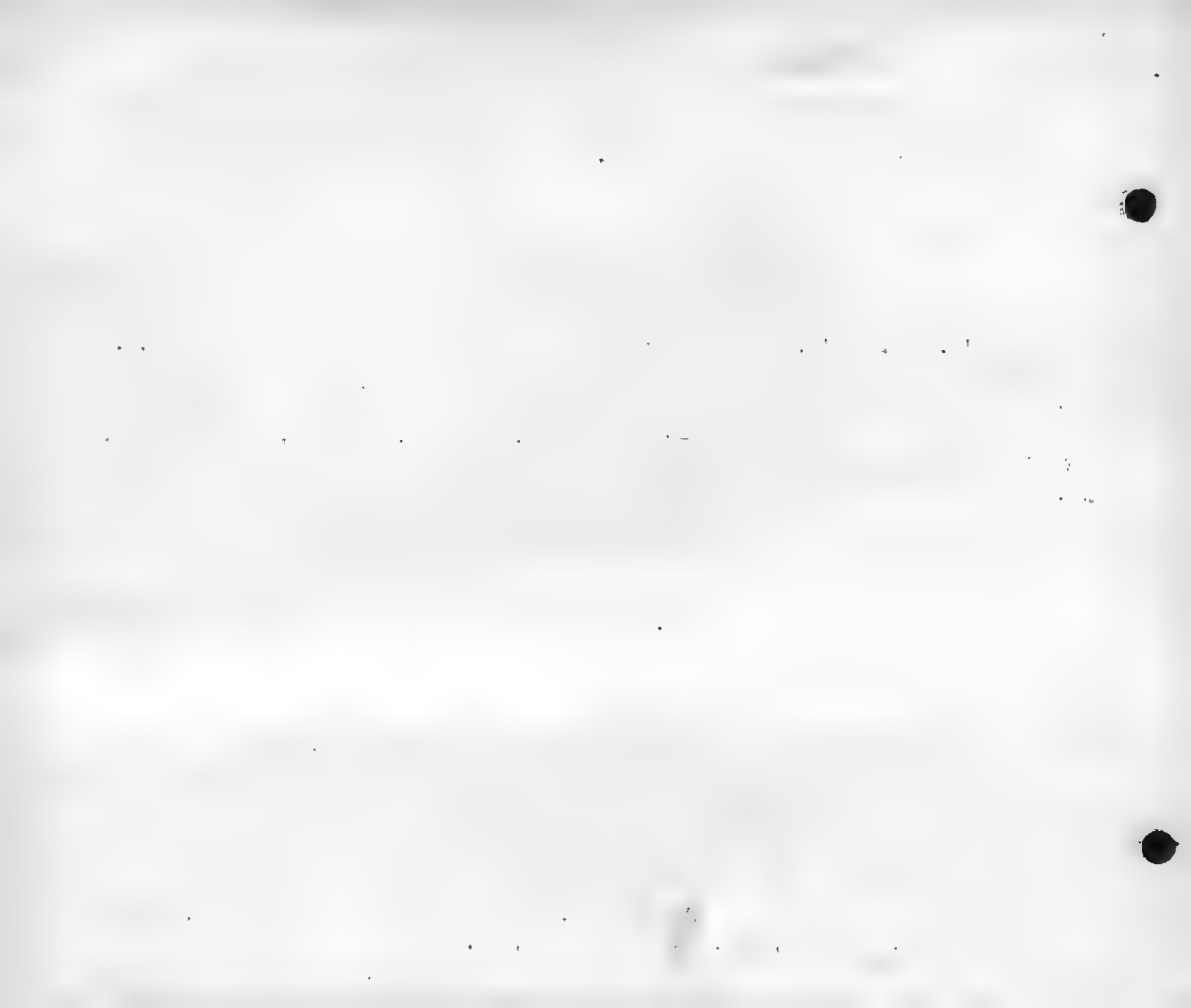
VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10390

10374

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 10 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9506 Ocala Street		d. STREET ADDRESS 9506 Ocala Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ELIZABETH Last BEALL		4. DATE OF DEATH Month 9 Day 16 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/76
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Mgr. Gov't. Cafeteria (retired)		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RHYNALDO SNYDER		14. MOTHER'S MAIDEN NAME HARRIETT POOLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-09-7411	
17. INFORMANT Mrs. Thelma B. Matthews, 9506 Ocala St.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility INTERVAL BETWEEN ONSET AND DEATH @ 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 12 53 to Sept 13 60 , that (I) (we) last saw the deceased alive on Sept 13 1960 , and that death occurred at 7:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 217 UNIVERSITY BLVD E., S.S. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9/20/60	23c. NAME OF CEMETERY OR CREMATORY SALEM METH. CHURCH CEMETERY	23d. LOCATION (City, town, or county) (State) CEDAR GROVE, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Jaska		25a. REC'D BY REGISTRAR DATE SEP 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



1
M
m
I
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10442
CERTIFICATE OF DEATH

10375

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.	
c. LENGTH OF STAY IN 1b 9 months		d. STREET ADDRESS 10011 Brunett Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last J. Leonard Bean		4. DATE OF DEATH Month Day Year Sept. 11 1960	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov't		10b. KIND OF BUSINESS OR INDUSTRY Govt.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BenJ. A. Bean		14. MOTHER'S MAIDEN NAME Mary F. Blundon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 month	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 3 1954 to Sept 11, 1960 , that (I) (we) last saw the deceased alive on Sept 11 1960 , and that death occurred at 5 PM , from the causes and on the date stated above.			
22a. SIGNATURE Raymond Bradshaw, Jr. M.D.		22b. DATE SIGNED 9/11/60	
22c. PHYSICIAN'S NAME (Type) Raymond Bradshaw, Jr.		22d. ADDRESS 345 University Blvd West Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/14/60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) (State) Bethesda, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Murphy		24b. ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR SEP 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

1
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10462
CERTIFICATE OF DEATH

10376

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY Herndon	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS Route #1	
3. NAME OF DECEASED (Type or print) First Grace Middle Mae Last BEARD		4. DATE OF DEATH Month Sept. Day 5th Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3 86
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min 74	11. IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Beard		14. MOTHER'S MAIDEN NAME Mary Siebert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert H. Beard CTC USN		U.S. Naval Security Station, Wash., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus (c) Urolithiasis + pyelonephritis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-11 1960 to 9-5 1960 , that (I) (we) last saw the deceased alive on 9-5 1960 , and that death occurred at 12:58 AM , from the causes and on the date stated above			
22a. SIGNATURE John H. Mazur LT MC USN			
22b. DATE SIGNED 9-5-60			
22c. PHYSICIAN'S NAME (Type) John H. Mazur LT MC USN			
22d. ADDRESS U. S. NAVAL HOSPITAL, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 7-1960	
23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cemetery		23d. LOCATION (City, town, or county) (State) Herndon Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Green Funeral Home, Herndon, Virginia		25a. REC'D BY REGISTRAR SEP 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10463

CERTIFICATE OF DEATH

Reg. Dist. No.

10377

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb. <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4883 Pathway Lane, Apt. #1</u>		d. STREET ADDRESS <u>14883 Pathway Lane, Apt. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Olga A. Benedict</u>		4. DATE OF DEATH <u>Sept 3 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1919</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR <u>41</u> Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cashier</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11c. BIRTHPLACE (State or foreign country) <u>Beaumont, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alex Angelo</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Kistha</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Yes Unknown</u>	
17. INFORMANT <u>Husband - Mr. Henry Benedict</u>		Address <u>4883 Pathway Apt. #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension</u> DUE TO (c) <u>5 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Sept</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 1</u> , 19 <u>60</u> , and that death occurred at <u>9:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter R. Ehrmantraut</u> M.D.		ADDRESS (Street, city or town, state) <u>4890 Pathway Lane, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Walter R. Ehrmantraut</u>		DATE SIGNED <u>9/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-6-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Walter R. Ehrmantraut</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10433

CERTIFICATE OF DEATH

Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

10378

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7107 Pomander Lane		d. STREET ADDRESS 7107 Pomander Lane	
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last BENTZ		4. DATE OF DEATH Month Sept. Day 23, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1881
9. AGE (In years last birthday) yrs 78		IF UNDER 1 YEAR Months 8 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY England Illinois	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Turk		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Husband		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abscess, chronic abdominal DUE TO Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 months 1 year
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1960 to Sept. 23, 1960 that (I) (we) last saw the deceased alive on Sept. 19, 1960 and that death occurred at 8:15 AM from the causes and on the date stated above			
22a. SIGNATURE Thomas A. Wildman		22b. DATE SIGNED 9-23-60	
22c. PHYSICIAN'S NAME (Type) THOMAS A. WILDMAN		22d. ADDRESS 3729 Morrison St. NW, Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 26, 1960	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City, town, or county) (State) Montgomery County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR DATE SEP 27 '60		25b. REGISTRAR'S SIGNATURE Robert S. Thomas	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10370

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10309 Keensington Parkway</u>		d. STREET ADDRESS <u>1371 Locust Rd NW</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mark Hanna Blacker</u>		4. DATE OF DEATH Month Day Year <u>Sept 1 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-10</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GIFT SHOP</u>	11. BIRTHPLACE (State or foreign country) <u>N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.E.</u>			
13. FATHER'S NAME <u>Frank Blacker (DEC.)</u>		14. MOTHER'S MAIDEN NAME <u>Lea Roman (DEC.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>230-10-9504</u>	
17. INFORMANT <u>Nathan Needle</u>		Address <u>9608 Clearview Pl. Silver Spring, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/4/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM PARK</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deborah Kuehl</u>		ADDRESS <u>Home 4217-9th Ave</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Knead</u>	
DATE <u>SEP 6 '60</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
M
10391

10380

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b. 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 406 Hinsdale Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 406 Hinsdale Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Earl Blair		4. DATE OF DEATH Month Sept Day 17 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Col. USA		10b. KIND OF BUSINESS OR INDUSTRY retired	
11. BIRTHPLACE (State or foreign country) Ark.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edw. Thomas Blair		14. MOTHER'S MAIDEN NAME Cherry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Virginia Blair (wife)		Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 900.0 DUE TO Fracture of Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Coronary occlusion PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
INTERVAL BETWEEN ONSET AND DEATH sudden			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell down basement steps at home	
20c. TIME OF INJURY Month, Day, Year Hour 6:00 p.m. 9/17/60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Silver Spring, Montg. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. DATE THEREOF 20 SEPT. 1960		22b. LOCATION (City, town, or country) (State) ARLINGTON VA.	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Russell Funeral Home		24a. REC'D BY REGISTRAR SEP 22 '60	
ADDRESS 816 H St. N.E. W.C. Rd		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

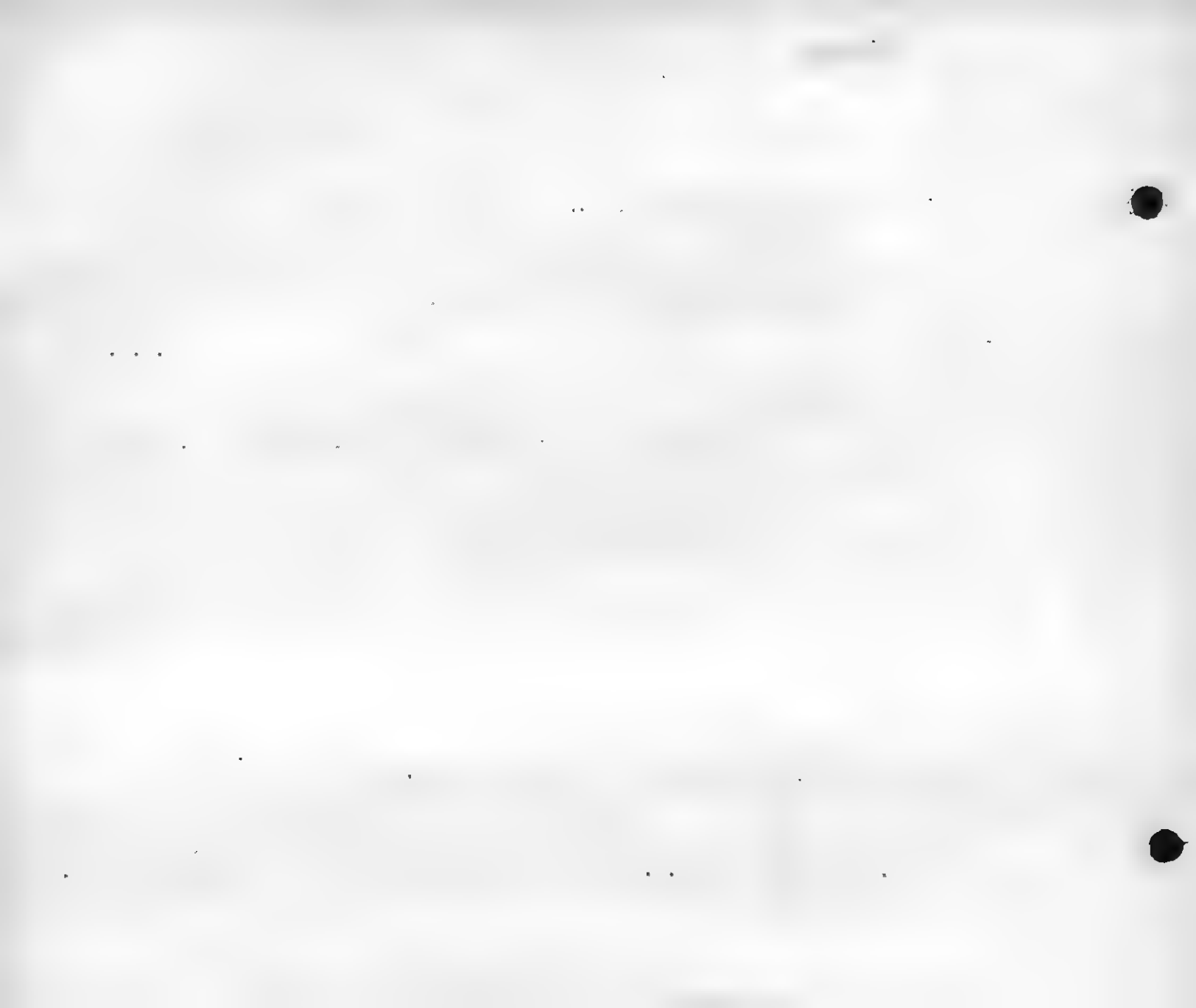
VR A15 (4)
ISM 9/59

10464

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10381

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Illinois Illinois b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 97 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmi	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 211 State Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Martha Middle Christine Last Blanton		4. DATE OF DEATH Month September Day 11 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1953
9. AGE (in years lost birthday) 7 yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Blanton		14. MOTHER'S MAIDEN NAME Helen Sawyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pseudomonas septicemia 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphatic leukemia DUE TO (c) 13 months		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 6, 1960 to September 11, 1960 that (I) (we) last saw the deceased alive on September 11, 1960 and that death occurred at 6:45 AM from the causes and on the date stated above			
22a. SIGNATURE W. Walter Oppelt M.D.		22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
22c. PHYSICIAN'S NAME (Type) W. WALTER OPPELT, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, or DISPOSAL (Specify) SHIR R.R. 9-12-60		23b. DATE THEREOF 9-12-60	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) CARMIL 146	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. 1400 Chapin St. N.E.		25a. REC'D BY REGISTRAR DATE SEP 19 '60	
25b. REGISTRAR'S SIGNATURE C. L. H. H. H.			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10392

CERTIFICATE OF DEATH

10382

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charleston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2105 Reedy Drive Reedy Drive		d. STREET ADDRESS 1510 Dixie Street	
3 NAME OF DECEASED (Type or print) First JOSEPH Middle H. Last BLOOM		4. DATE OF DEATH Month Sept. Day 4 Year 19 60	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug 22, 1889
9. AGE (in years last birthday) yrs 71		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer (Ret)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Roumania		12 CITIZEN OF WHAT COUNTRY? Roumania	
13. FATHER'S NAME Joseph Bloom		14. MOTHER'S MAIDEN NAME Minnie Peck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or greenhown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 235-12-5568	
17. INFORMANT Rose M. Bloom		1510 Dixie Street Charleston, West Virginia	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction (c) Senile arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH moments years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Aug 1960 to Sept 4 1960 that (I) (we) last saw the deceased alive on Aug 1960 and that death occurred at 12:00 M, from the causes and on the date stated above			
22a. SIGNATURE Abraham W. Danish		22b. DATE 9-4-60	
22c. PHYSICIAN'S NAME (Type) Abraham W. Danish		22d. ADDRESS 927 Pershing Dr., Silver Spring, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Wood Cemetery		23d. LOCATION (City, town, or county) (State) Wheeling, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE 4217 9th Street N.W.		25a. REC'D BY REGISTRAR SEP 7 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD STATE DEPARTMENT OF HEALTH

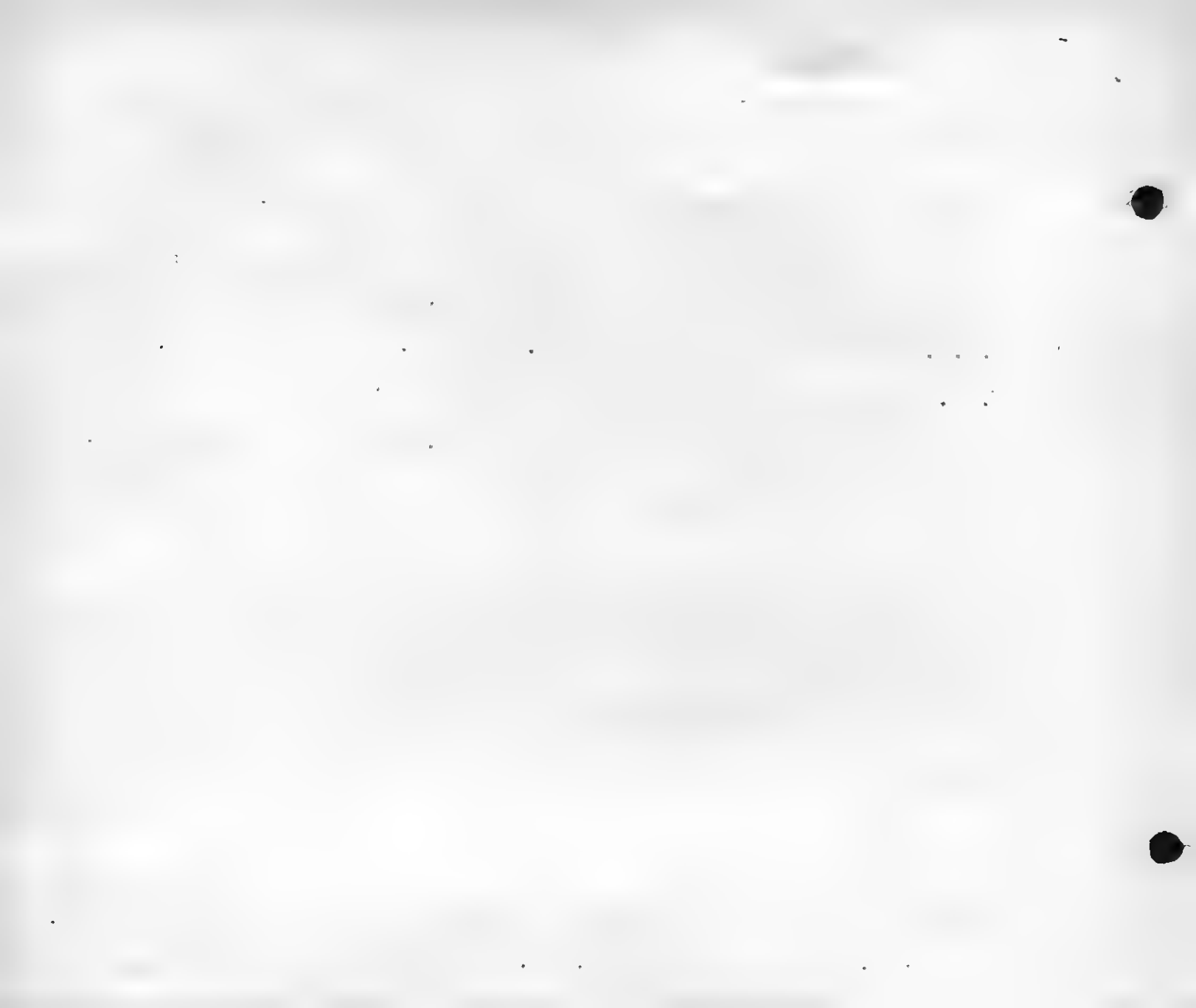
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10444

CERTIFICATE OF DEATH

10383

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4400 Glenridge Street		e. STREET ADDRESS 4400 Glenridge St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDNA Middle P. Last BOHRER		4. DATE OF DEATH Month Sept. Day 9, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1890
9. AGE (In years last birthday) yrs 70		IF UNDER 1 YEAR Months 2 Days 17	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.B.X. Operator		10b. KIND OF BUSINESS OR INDUSTRY Apartment Bldg.	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME B. F. Ryan		14. MOTHER'S MAIDEN NAME Maude Henry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Daughter Shirley B. Heflin		Address Same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420. Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction. (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 4 19 60 , to Sept 7 19 60 , that (I) (we) last saw the deceased alive on Sept 7 19 60 , and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Robert Kramer		22b. DATE SIGNED 9-10-60	
22c. PHYSICIAN'S NAME (Type) Robert Kramer		22d. ADDRESS 1703 So. West Highway 55	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 9-12-60	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

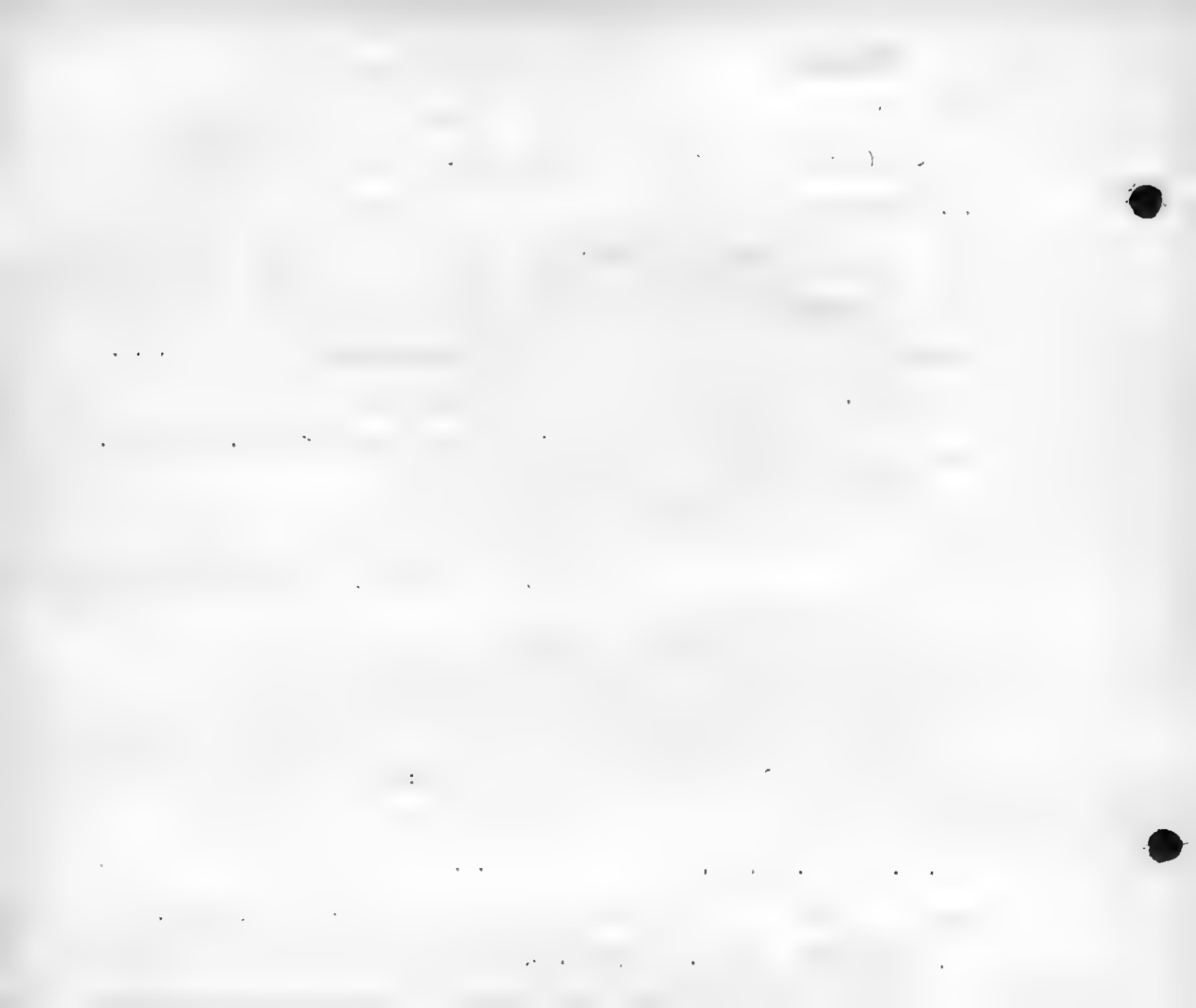


TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10465
10384
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN TB 2 Months 27 days McLean d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY McLean c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McLean d. STREET ADDRESS 4314 Oakdale Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Esther Harris BOODA		4. DATE OF DEATH Month Day Year September 15 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-91
9. AGE (In years last birthday) 68 yrs		IF UNDER 1 YEAR Months Days Hours Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. HARRIS		14. MOTHER'S MAIDEN NAME Emma SANDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Larry BOODA, 4314 Oakdale Rd., McLean, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO (b) Anemia DUE TO (c) Generalized Metastatic Adenocarcinoma Endometrium PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 mo 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-19-1960 to 9-15-1960 , that (I) (we) last saw the deceased alive on 9-15-1960 , and that death occurred 12:20 PM from the causes and on the date stated above.			
22a. SIGNATURE R. F. Mading		22b. DATE SIGNED 9-15-60	
22c. PHYSICIAN'S NAME (Type) R. F. MADING, LT JG, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) Removal		23b. DATE THEREOF 9/16/60	
23c. NAME OF CEMETERY OR CREMATORY Paxtang Cemetery		23d. LOCATION (City, town, or county) (State) Harrisburg, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines		25a. REC'D BY REGISTRAR SEP 20 1960	
25b. REGISTRAR'S SIGNATURE Charles L. Hines			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA AIS (4)
15M 9/59

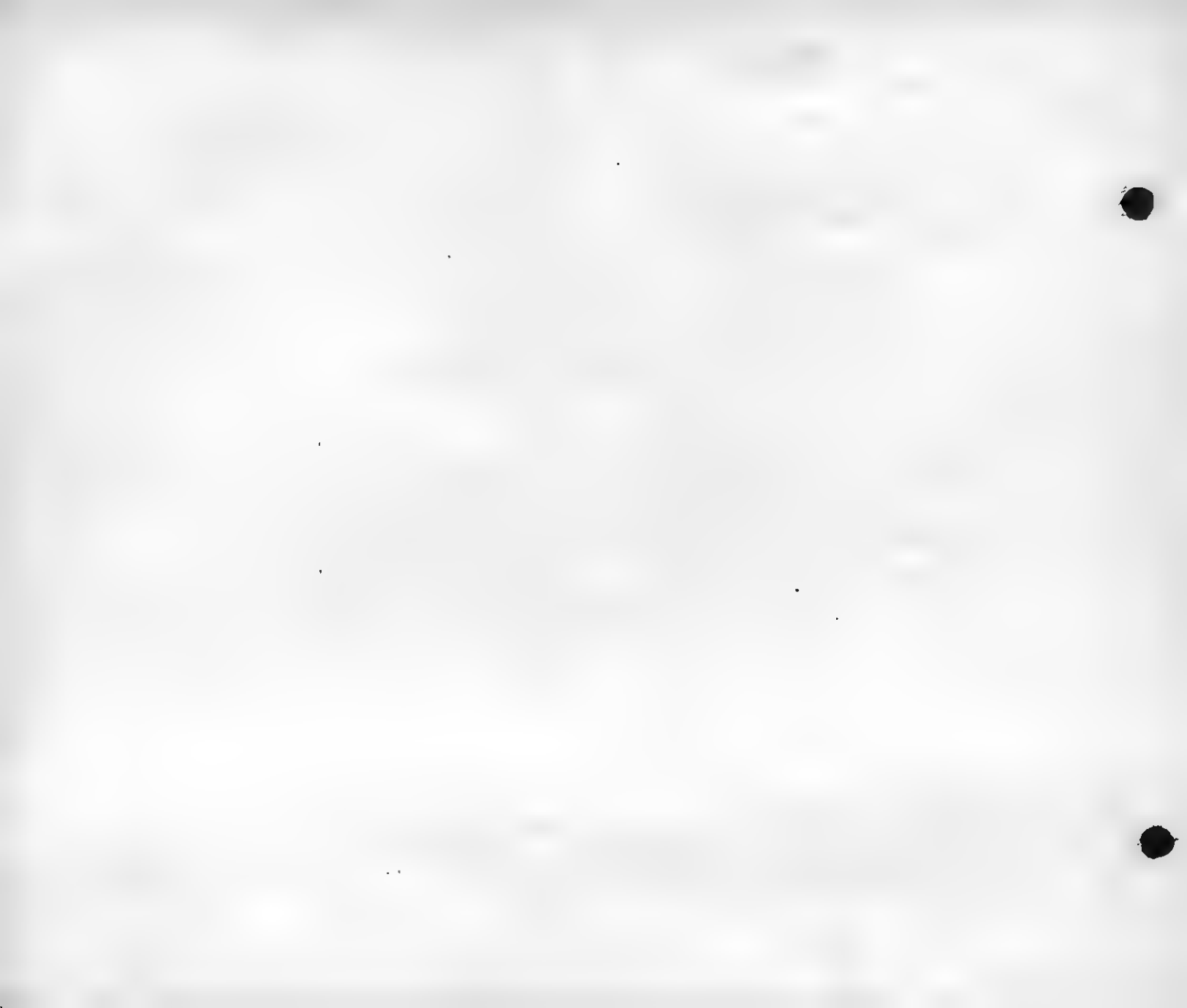
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10285

10413

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK MD</u>		c. LENGTH OF STAY IN 1b <u>80 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		d. STREET ADDRESS <u>17711 Greenwood AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>MARIE</u> Last <u>BOWEN</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-96</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hood</u>		14. MOTHER'S MAIDEN NAME <u>MARIE HUNT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory embarrassment and hyperpyrexia</u> DUE TO <u>BRAIN stem compression</u> (b) <u>Due to probable brain tumor</u> DUE TO <u>Progressive cerebro-vascular insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 to 3 weeks</u> <u>3 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1960</u> Hour <u>a. m.</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1960</u> to <u>Sept 15, 1960</u> that (I) (we) last saw the deceased alive on <u>9/14</u> 19 <u>60</u> and that death occurred on <u>15</u> A.M. from the causes and on the date stated above			
22a. SIGNATURE <u>John T. Lord</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord M.D.</u>		22d. ADDRESS <u>909 Pershing Dr. Silver Sp. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 19-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick - West Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. ADDRESS	



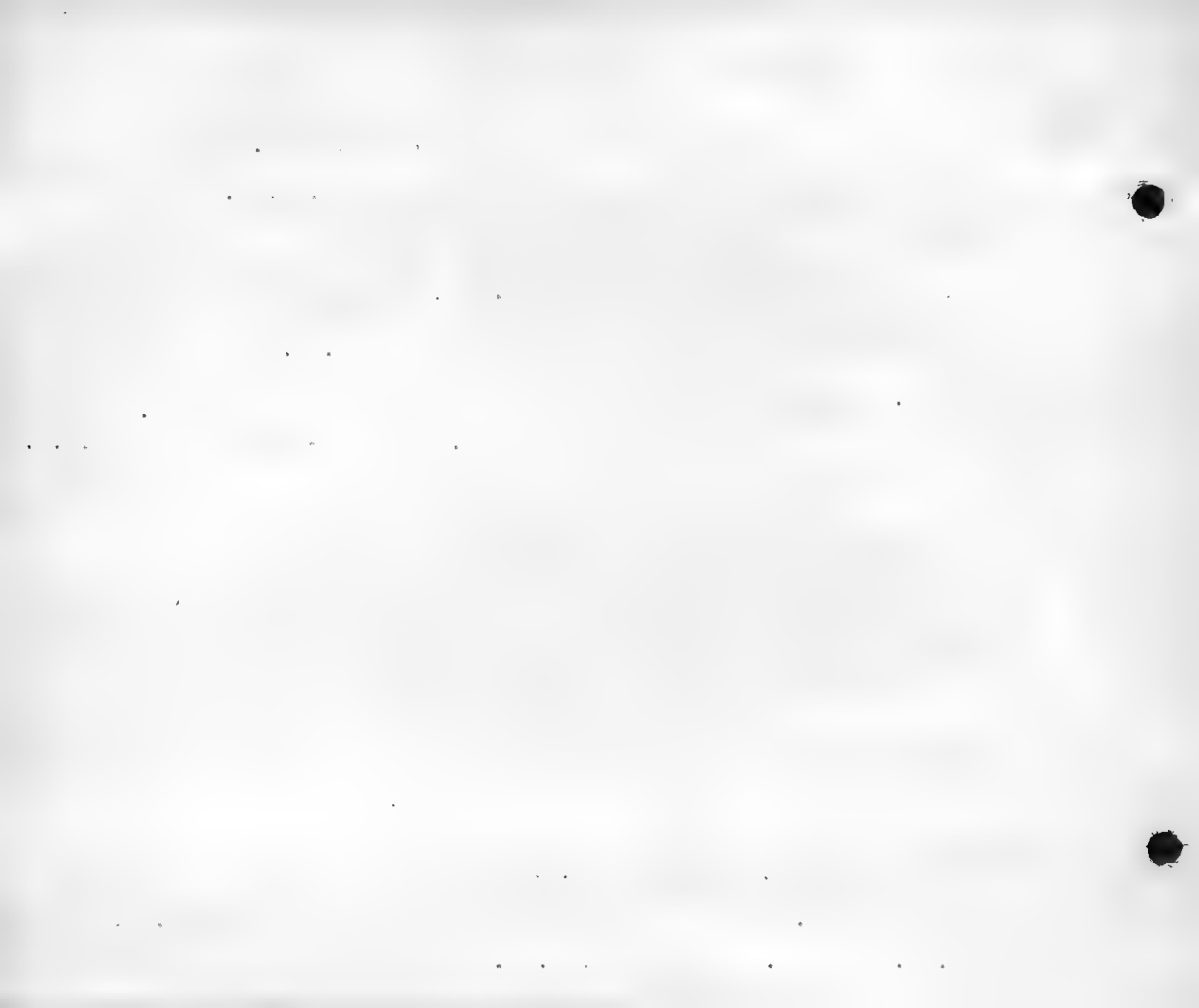
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10393
CERTIFICATE OF DEATH

10386

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 13 Mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 3335 Quesada St. N. W.	
3. NAME OF DECEASED (Type or print) First LOTTIE Middle E Last Bradford		4. DATE OF DEATH Month September Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1876
9. AGE (In years last birthday) 83 yrs		10. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James O. Carter		14. MOTHER'S MAIDEN NAME Mary McEvoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Thomas A. Bradford-3335 Quesada, St. N.W.		Address Wash. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Degilitation DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Peritonitis DUE TO (c) Diverticulitis, Colon		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 48 hrs 48 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 15, 1960 to Sep 23, 1960 that (I) (we) last saw the deceased alive on Sep 23, 1960 , and that death occurred at 10:20pm M, from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau M.D.		22b. DATE SIGNED Sept 23, 1960	
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		22d. ADDRESS 10602 Concord St., Kensington, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26/1960	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		25a. REC'D BY REGISTRAR SEP 27 '60	
ADDRESS Washington, D. C.		25b. REGISTRAR'S SIGNATURE Charles L. Hines	



10394

CERTIFICATE OF DEATH

10387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY in 1b 11/21/54 - 1/4/60		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarcroft Sanitarium & Hospital				d. STREET ADDRESS 1707 Columbia Rd NW			
3. NAME OF DECEASED (Type or print) First John Middle M. Last Brinton				4. DATE OF DEATH Month 9- Day 4 Year 1960			
5. SEX M.	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-1870		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor for Internal Revenue		10b. KIND OF BUSINESS OR INDUSTRY Federal Gov.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Nephew		Address Chevy Chase, Md C. M. Bloodgood-6635 Hillendale Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 32x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 20, 1958 to 9-4, 1960 , that I last saw the deceased alive on 9-4, 1960 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1429 University Blvd, W. Silver Spring, Md. DATE SIGNED 9-4-'60							
ACTUAL SIGNATURE Aldo Vacca		M.D. 1429 University Blvd, W. Silver Spring, Md.					
PHYSICIAN'S NAME (Type) Aldo Vacca							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 9/7/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 9 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10414

10388

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1st</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakons Park</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Georgetown Rehab. Home</u> <u>7300 Eastmore Avenue</u>				d. STREET ADDRESS <u>6923 Maple St. NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>RUTH</u> First <u>BRISCOE</u> Middle Last				4. DATE OF DEATH <u>Sept</u> Month <u>22</u> Day <u>1960</u> Year			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 25, 1871</u>	
9 AGE (In years last birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Philip E. Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Willie Humphries</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Philip E. Briscoe, Jr., 7000 Poplar Ave T.P.M.D.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.00</u> DUE TO <u>Arterio-Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a m p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>8/6</u> 19 <u>56</u> to <u>9/22</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>9/21</u> 19 <u>60</u> , and that death occurred at <u>7</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>A. B. Little</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/22/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE</u>				22d. ADDRESS <u>Washington, D.C.</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Sept. 24, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Hatten</u> ADDRESS <u>251 Carroll St. D.C.</u>				25a. REC'D BY REGISTRAR <u>SEP 26 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>C. H. S. Hatten</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M III/59

1

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

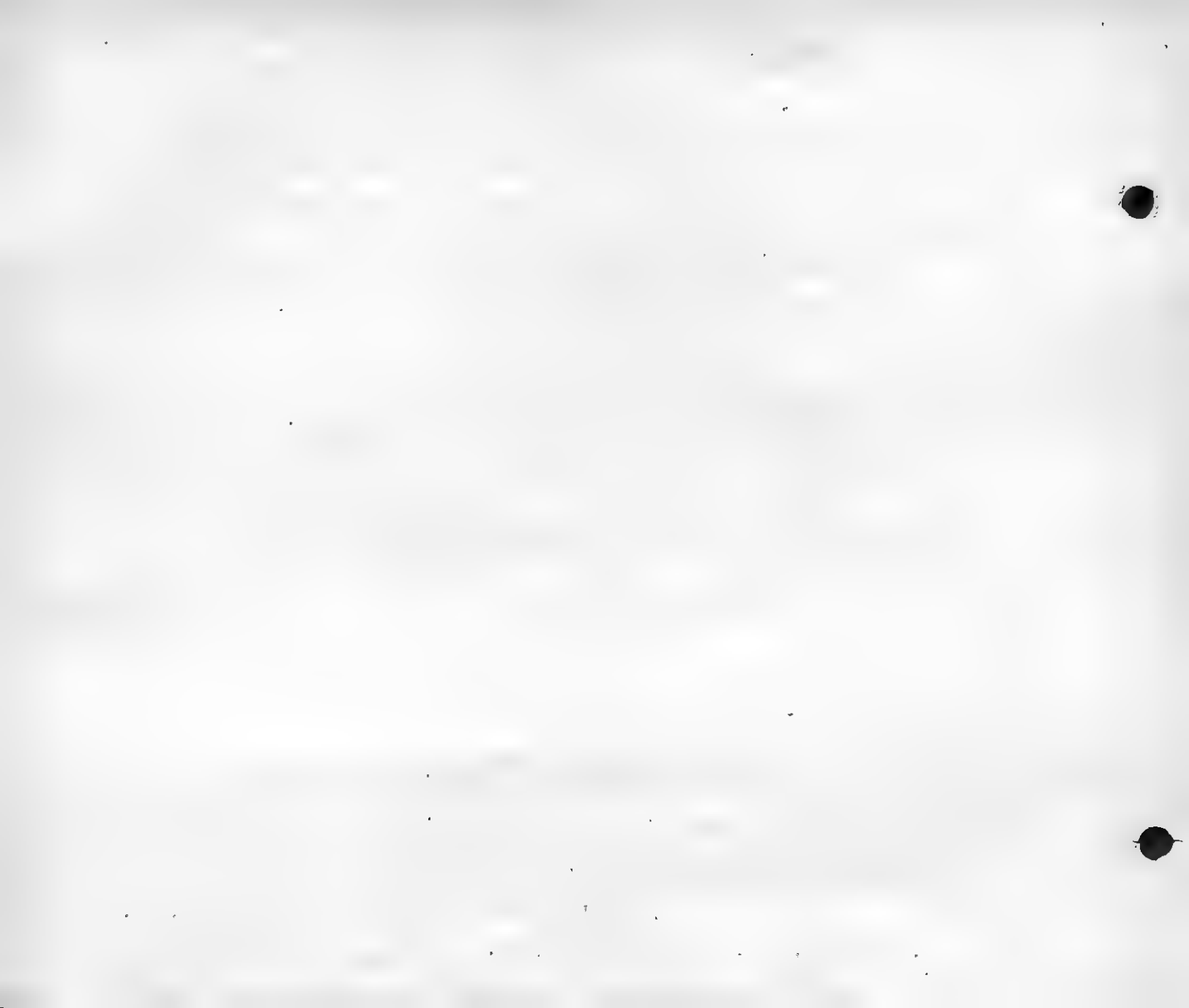
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10395

10389

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut an: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>9 months</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9500 Saginaw Avenue</u>		d STREET ADDRESS <u>9500 Saginaw Ave</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Lena Virginia Brown</u>		4 DATE OF DEATH Month Day Year <u>Sept. 1 1960</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1886</u>
9 AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred C. Tolson</u>		14. MOTHER'S MAIDEN NAME <u>Kathrine Elizabeth O'Hare</u>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT (son) Address <u>Wash, D.C.</u> <u>John C. Brown, 7413 Blair Rd. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia.</u> <u>450-0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u>10 years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Aug. 1, 1960</u> to <u>Sept. 1, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug. 26, 1960</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Humphreys, Jr.</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>9/1/60</u>	
22c PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, Jr.</u>		22d. ADDRESS <u>1746 K St. N.W. Washington D.C.</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>9/3/60</u>	23c NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	23d LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>Raymond G. Jiska</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>	
25b REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10466

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10390

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
c. LENGTH OF STAY IN 1b 12 hrs., 50 min.		d. STREET ADDRESS 4626 Knox Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Jeffrey Last BUGG		4. DATE OF DEATH Month 9 Day 23 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-60
9. AGE (In years last birthday) yrs 12 Min 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. E. BUGG, Jr.		14. MOTHER'S MAIDEN NAME Jane Souders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS OF NEWBORN 162.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATURITY DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-23, 1960 to 9-23, 1960 , that (I) was last saw the deceased alive on 9-23, 1960 , and that death occurred at 3:10 AM , from the causes and on the date stated above			
22a. SIGNATURE Mary R. L. Sartwell		22b. DATE SIGNED 9-23-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 6811 RIGGS RD, HYATTSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
cremation		7-23-60	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Suburban Hospital		8600 CH Rockledge Rd. Bethesda, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Suburban Hospital		24. ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR OCT 6 '60		25b. REGISTRAR'S SIGNATURE William L. Kline	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~and~~ duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
#

10467

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10391

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 1/2</u> MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1111 Agnew Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Christine Campbell</u>		4. DATE OF DEATH Month Day Year <u>Sept 27 1960</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-03</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Ill.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul Peterson</u>		14. MOTHER'S MAIDEN NAME <u>Landgren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wilfred P. Campbell - Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIAL HYPERTENSION</u> DUE TO (c) <u>CORONARY ARTERY DISEASE</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GASTRIC ULCER -</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>16 HRS.</u>		15 YEARS <u>15 YEARS</u> 10 YEARS <u>10 YEARS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 27 1960</u> to <u>SEPT. 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 27 1960</u> , and that death occurred at <u>7:25</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D.		22b. DATE SIGNED <u>SEP 27, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>		22d. ADDRESS <u>316 W. Montgomery Avenue Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/1/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkland</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>1331 E. Montgomery Ave. Rockville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>	

SEP 29 1960

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10468

10392

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 90 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 207 Claude Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Lucy Middle CARLE Last CARLE		4. DATE OF DEATH Month September Day 21 Year 19 60	
5 SEX Female	6 COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-83
9 AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76	IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Weippert		14. MOTHER'S MAIDEN NAME Mary Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (D) Mrs. Hilda M. Hardesty, Bethesda, Md.		4506 Chase Ave.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis 332X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (physician) attended the deceased from June 23 19 60 , to Sept. 21 19 60 , that (I) (x) saw the deceased alive on Sept. 21 1960, and that death occurred at 5:45 PM M, from the causes and on the date stated above			
22a. SIGNATURE R. G. Muth		22b. DATE SIGNED 7-22-60	
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 9-24-60	
23c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, 6209 Bimbank Ave, Balto, Md.		25a. REC'D BY REGISTRAR DATE SEP 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

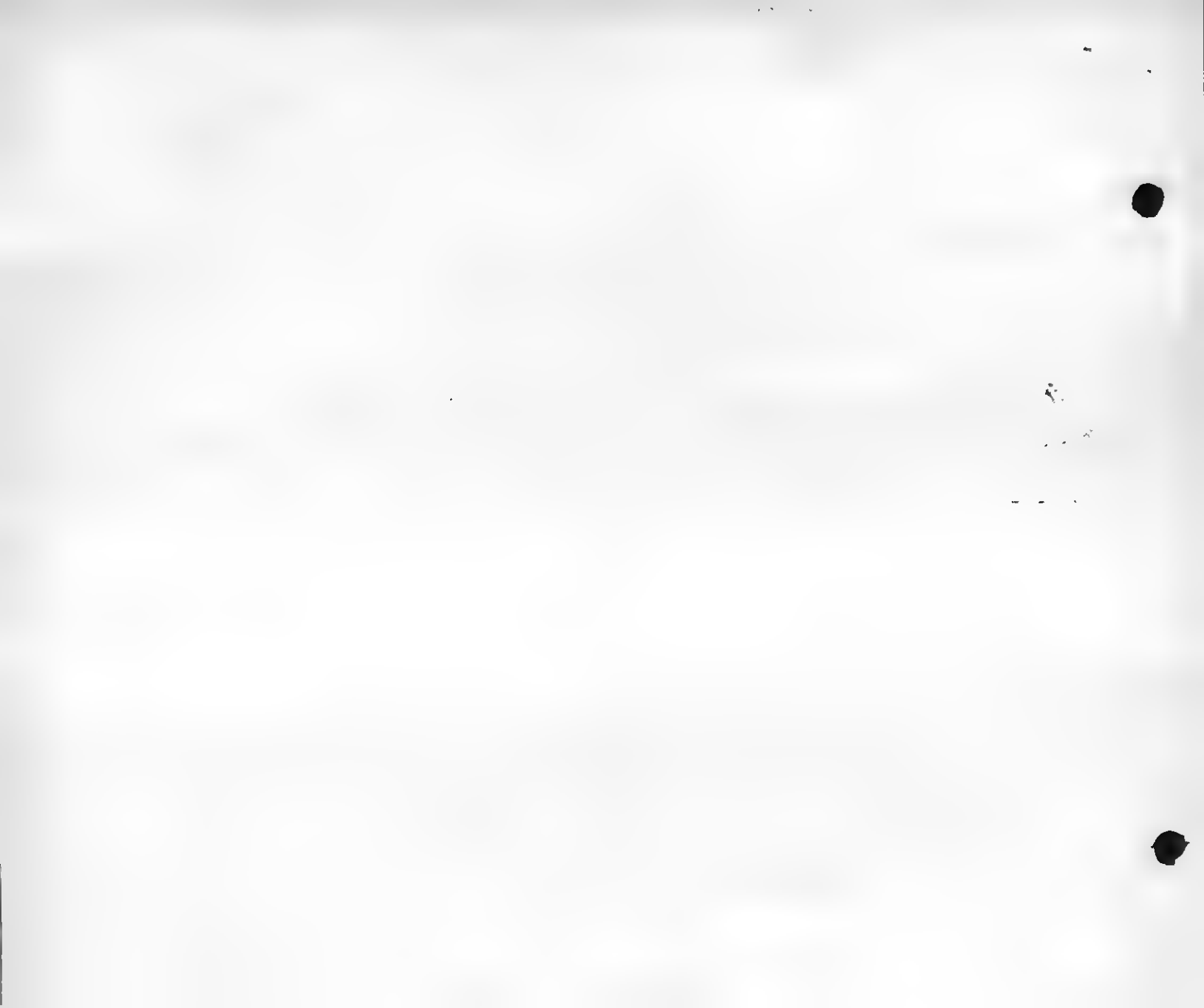
North of Emma Ave.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 HRS. 8 MIN. X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 7 NEW STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last TERRY LEE CARLIN		4. DATE OF DEATH Month Day Year SEPTEMBER 27 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/60
9. AGE (In years last birthday) yrs		10. BIRTHPLACE (State or foreign country) MARYLAND	
11. CITIZEN OF WHAT COUNTRY? U. S. A.			
12. FATHER'S NAME JAMES DAVID CARLIN		13. MOTHER'S MAIDEN NAME OPAL MARIE WOOD	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		15. SOCIAL SECURITY NO. HOSPITAL RECORDS, OLNEY, MD.	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 762.5 DUE TO (b) Precipitancy (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/27, 1960, to 9/27, 1960 that I last saw the deceased alive on 9/27, 1960, and that death occurred at 4:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. D. Bonifant, M.D.		DATE SIGNED 9/28/60	
PHYSICIAN'S NAME (Type) A. D. BONIFANT, M.D.		ADDRESS (Street, city or town, state) SANDY SPRING, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/28/60	22c. NAME OF CEMETERY OR CREMATORY Hyattstown Church Cem.	22d. LOCATION (City, town, or county) (State) Hyattstown Maryland
23. FUNERAL DIRECTOR'S SIGNATURE T. S. Wheeler Funeral Home		24a. REC'D BY REGISTRAR DATE SEP 29 '60	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

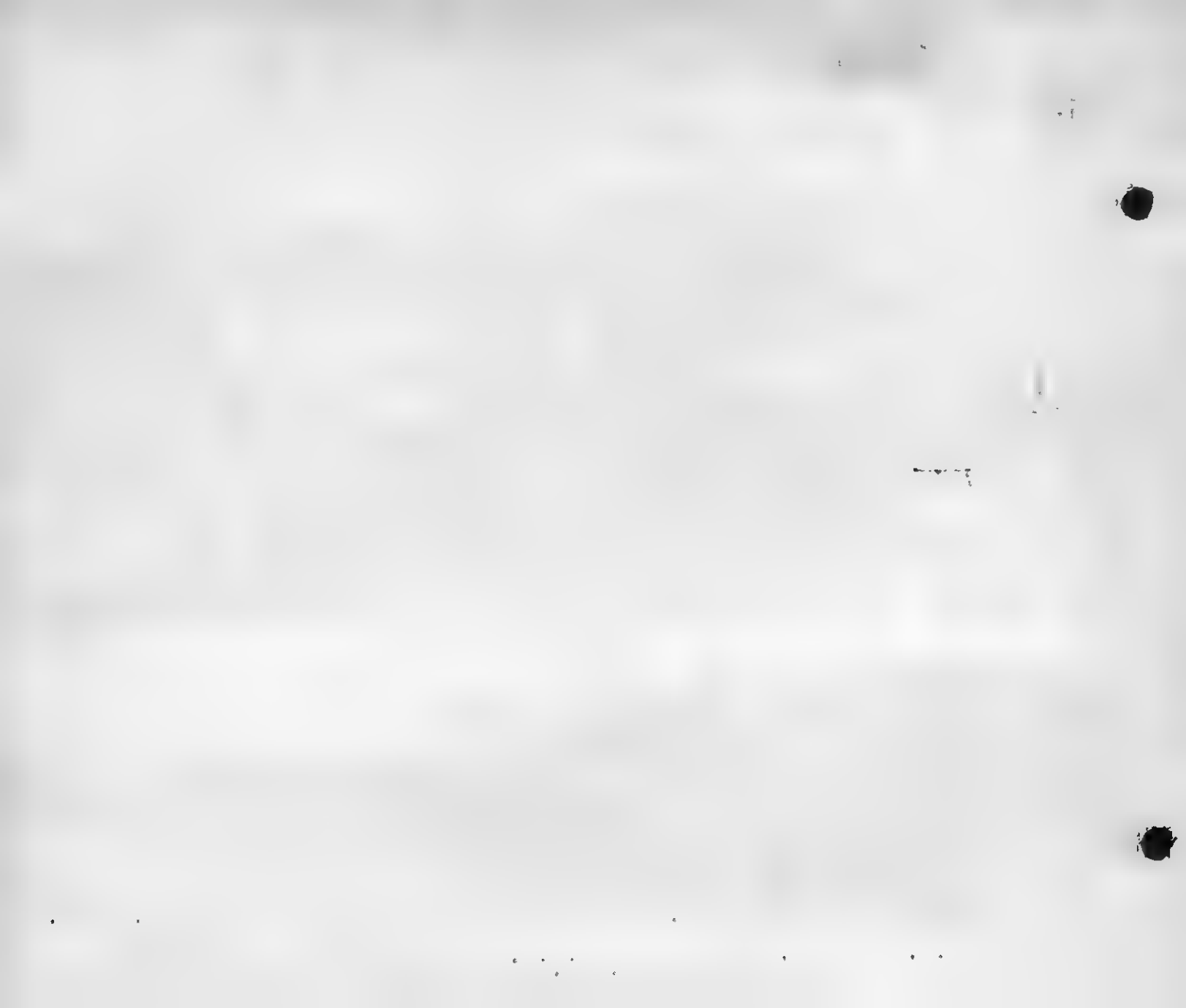
VS A15 (4)
15M 9/58



10434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Cherry Chase</u>			
c. LENGTH OF STAY IN b. <u>1 yr.</u>				d. STREET ADDRESS <u>8804 Walnut Hill Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8804 Walnut Hill Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Elbert Chase</u>				4. DATE OF DEATH <u>Sept 22 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone repair</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Chase</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>101-11-1890</u>			
17. INFORMANT <u>Louise Chase (wife)</u>				Address <u>Steu 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4-20-1</u> DUE TO (c) <u>4-20-1</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>4-20-1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>9/24/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>				22d. LOCATION (City, town, or country) (State) <u>Prince Georges Co. Md.</u>			
23. FUNERAL DIRECTOR <u>The S.H.Hines Co.-2901 14th St. N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 26 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				DATE SIGNED <u>9-22-60</u>			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with this. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10470

CERTIFICATE OF DEATH

10395

Reg. Dist. No.

1 PLACE OF DEATH o COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) o STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11904 CHARLES ROAD		d. STREET ADDRESS 10707 Jamaica Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First JENNIE Middle CHIPOURAS Last CHIPOURAS		4. DATE OF DEATH Month 9 Day 15 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Greece	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? Greece	
13. FATHER'S NAME Sam Zeavras		14. MOTHER'S MAIDEN NAME Staseni (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Angelo Chipouras-10707 Jamaica Drive		Address Silver Spring, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction massive DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) hypertension DUE TO Diabetes mellitus (c) 10+ Yrs INTERVAL BETWEEN ONSET AND DEATH sudden Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 3 , 19 59 , to Sep 15 , 19 60 , that I lost saw the deceased alive on Sept 15 , 19 60 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3900 -16th St. NW Washington, D.C. DATE SIGNED 9/15/60			
ACTUAL SIGNATURE Abel Blajwas		M.D. 3900 -16th St. NW Washington, D.C.	
PHYSICIAN'S NAME (Type) Abel Blajwas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/60	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR SEP 20 '60	
24b. REGISTRAR'S SIGNATURE Clifford S. Hines			



1
 M
 051
 10471
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 10396

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 402 d. STREET ADDRESS 2245 48th St., N.W. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Edward CLARK		4. DATE OF DEATH Month Day Year September 19 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-94
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William CLARK		14. MOTHER'S MAIDEN NAME Catherine FARRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI & WWII		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Marjorie S. CLARK, Same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infection of Myocardium DUE TO (b) Excessive exertion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Embolism		INTERVAL BETWEEN ONSET AND DEATH 7-10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 9-1- 19 60 to 9-19- 19 60 that (I) (we) last saw the deceased alive on 9-19- 19 60 , and that death occurred at 6:28 AM from the causes and on the date stated above.			
22a. SIGNATURE Joseph E. Stichter M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
22c. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons ADDRESS 1756 Penna Ave., N.W., Wash D.C.		25a. REC'D BY REGISTRAR SEP 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kimes			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

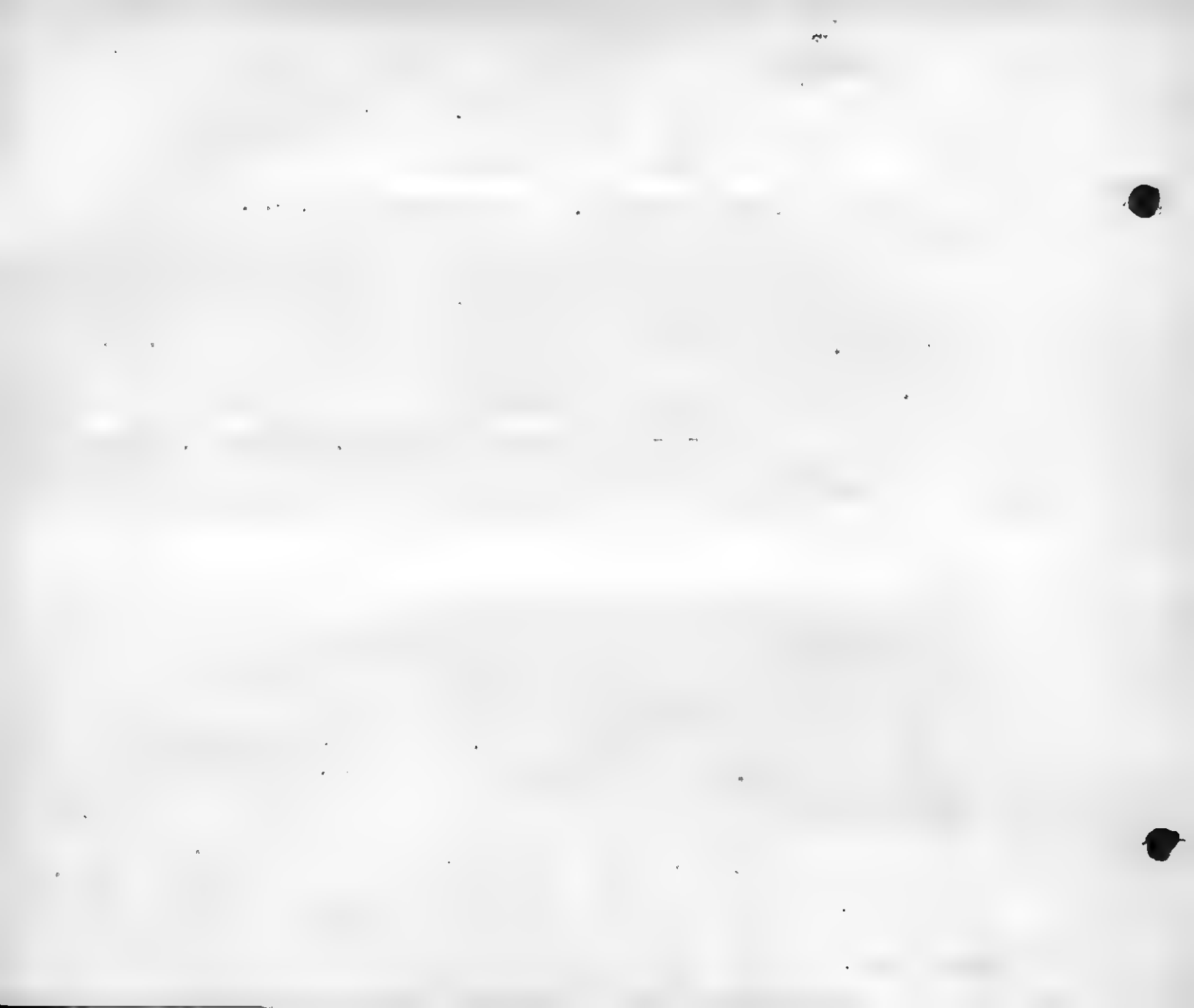
1

10472

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10397

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 103 Missouri Avenue, N.W.	
3 NAME OF DECEASED (Type or print) First Middle Last Ruth Mary Clayton		4. DATE OF DEATH Month Day Year September 28 19 60	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH May 14, 1924
9. AGE (In years last birthday) 36 yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11 BIRTHPLACE (State or foreign country) West Virginia		12 CIT ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie D. Warfe		14. MOTHER'S MAIDEN NAME Ora Brady	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. 240-22-5476	
17 INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widely disseminated carcinoma of the breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 170 X	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from September 13 19 60 to September 28 19 60 , that (I) (we) last saw the deceased alive on Sept. 28 19 60 , and that death occurred at 9:40 P.M. , from the causes and on the date stated above			
22a. SIGNATURE Leo Stolbach		22b. DATE SIGNED 9/29/60	
22c. PHYSICIAN'S NAME (Type) Leo Stolbach, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CCT 1, 1960		23b. DATE THEREOF 21XK	
23c. NAME OF CEMETERY OR CREMATORY GREENSBORO, N.C.		23d. LOCATION (City, town, or county) (State) GREENSBORO, N.C.	
24 FUNERAL DIRECTOR'S SIGNATURE Funeral Home 300-4 ST NE DC		25a. REC'D BY REGISTRAR OCT 3 '60	
25b. REGISTRAR'S SIGNATURE John A. Grand			



10473

CERTIFICATE OF DEATH

10398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN TB 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. STREET ADDRESS GERMANTOWN			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle WESLEY Last COE				4. DATE OF DEATH Month SEPT. Day 14 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/83	
				9. AGE (In years lost birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME SAMUEL COE				14. MOTHER'S MAIDEN NAME ANNIE HAYES			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Unknown			
				INFORMANT Address HOSPITAL RECORDS, OLNEY, MO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of prostate with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary heart failure from Arterio Sclerosis A.D.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from AUGUST 1956 to 9/14 19 60 that I last saw the deceased alive on 9/14 19 60 , and that death occurred at 4:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. F. Meadors M.D.				ADDRESS (Street, city or town, state) BOYER CLINIC DATE SIGNED 9/14/60			
PHYSICIAN'S NAME (Type) G. F. MEADORS, M. D.				DAMASCUS, MARYLAND			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 9-16-60		22c. NAME OF CEMETERY OR CREMATORY Fredericksburg Conf.		22d. LOCATION (City, town, or county) (State) Fredericksburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR DATE SEP 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10474

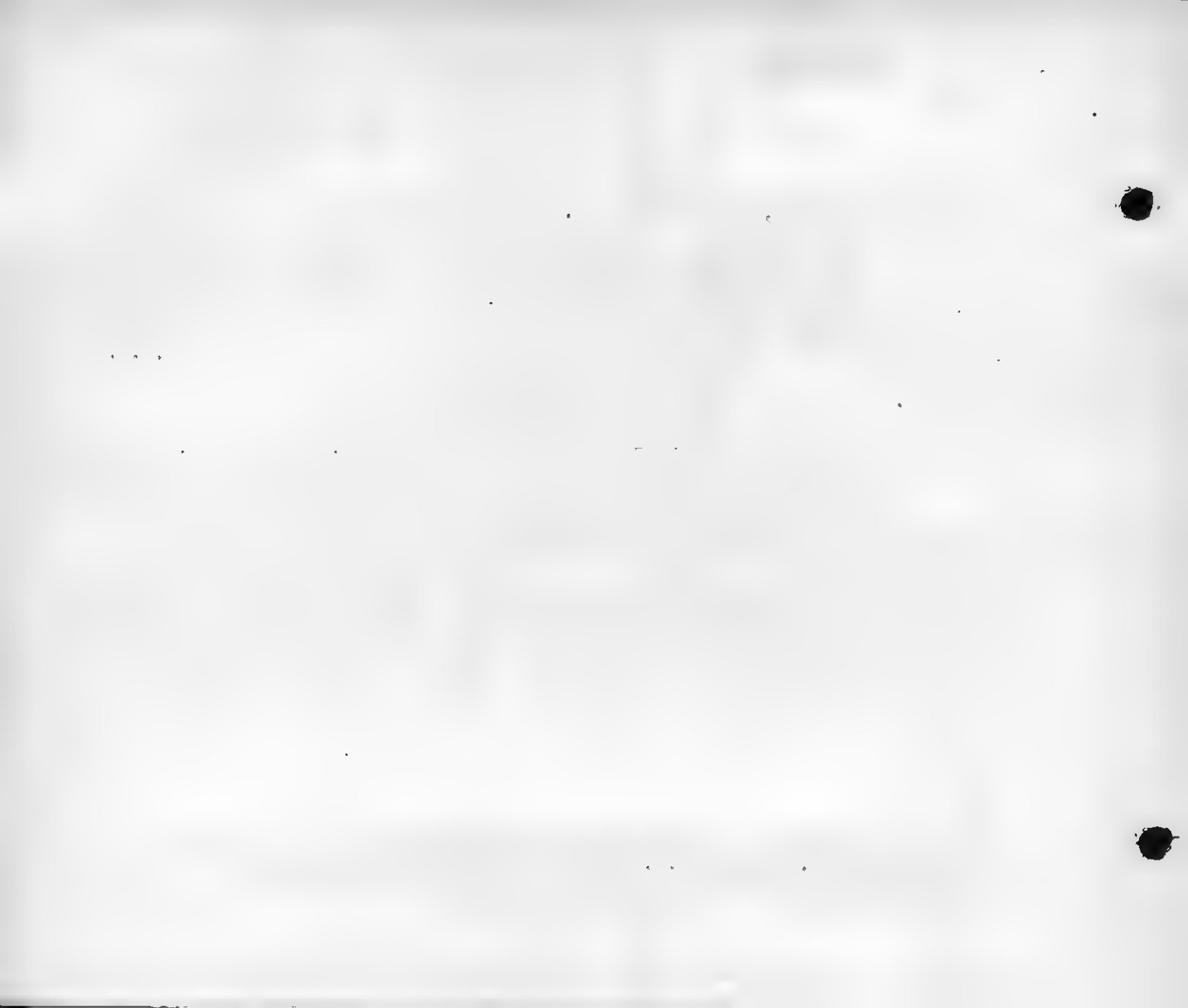
CERTIFICATE OF DEATH

Reg. Dist. No.

10399

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Massachusetts b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c LENGTH OF STAY IN 1b 20 days			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boston	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d STREET ADDRESS 315 Commonwealth Avenue			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Sarah Middle Dellow Last Cornish				4 DATE OF DEATH Month September Day 20 Year 1960			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH January 19, 1895	
9 AGE (In years last birthday) yrs 65		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher			10b KIND OF BUSINESS OR INDUSTRY Education			11 BIRTHPLACE (State or foreign country) New York	
12 CITIZEN OF WHAT COUNTRY? U.S.A.							
13 FATHER'S NAME George L. Hill				14 MOTHER'S MAIDEN NAME Franklina Hannahs			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO 030-20-6549		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Postoperative hemorrhage 467.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atrial Septal Defect DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 hours 65 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from August 31, 1960 to September 20, 1960 , that I last saw the deceased alive on September 20, 1960 , and that death occurred at 11:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/21/60 ACTUAL SIGNATURE Benson R. Wilcox M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Benson R. Wilcox, M.D. Bethesda 14, Maryland							
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/26/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE Robert A. Prophe				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 30 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kious			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

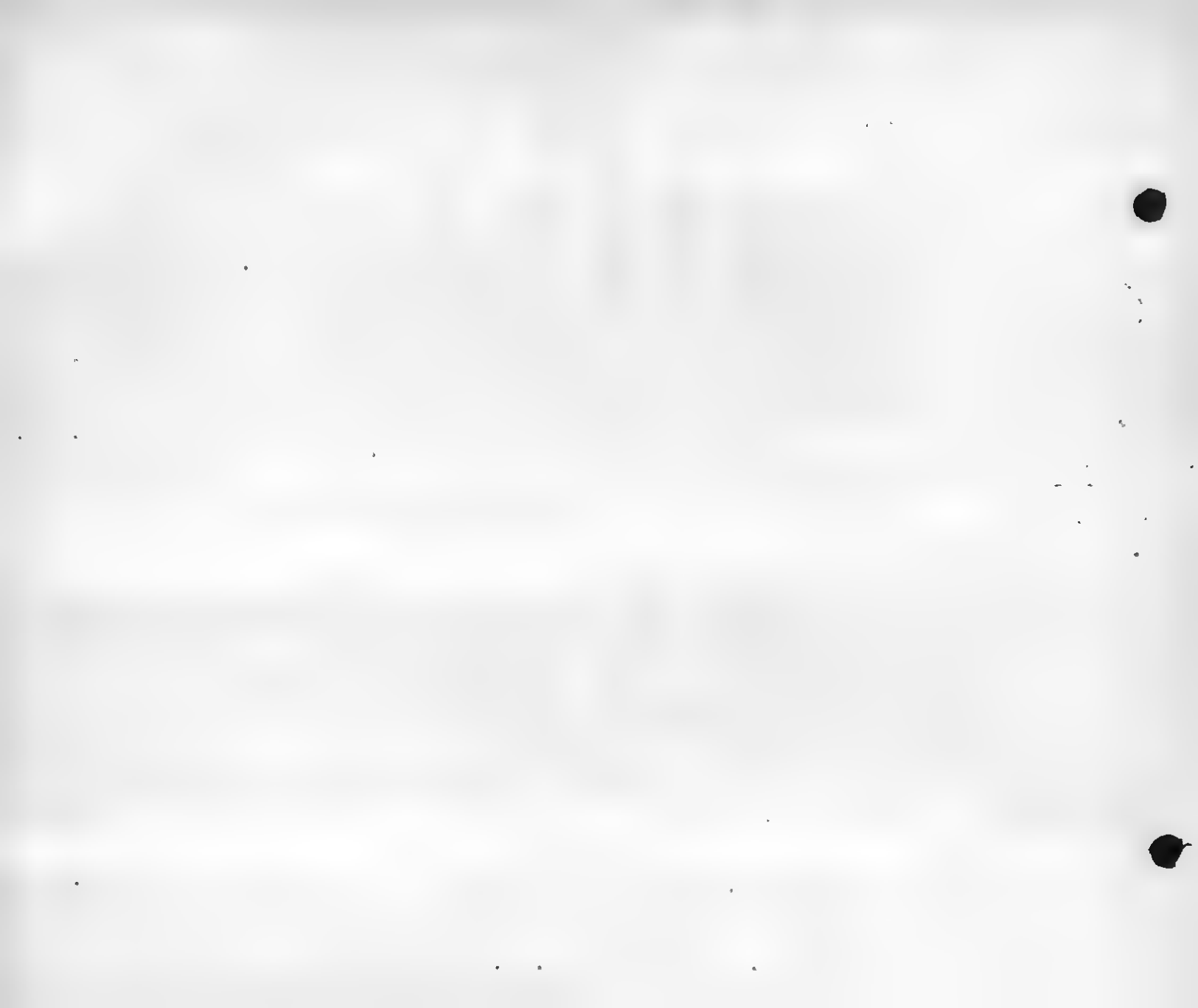
10415

CERTIFICATE OF DEATH

10400

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hosp.		e. STREET ADDRESS 2508 Jennings Court	
3. NAME OF DECEASED (Type or print) First John Middle Cozanas Last Cozanas		4. DATE OF DEATH Month Sept. Day 24 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/71
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR: Months 88 Days 88 Hours 88 Min 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired ?		10b. KIND OF BUSINESS OR INDUSTRY Greece	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Constantine Cozanas		14. MOTHER'S MAIDEN NAME Eva (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Washington San. & Hosp. Records.		Address Takoma Pk. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3-IX Congestive Heart failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). Arteriosclerosis; Pneumonia INTERVAL BETWEEN ONSET AND DEATH 7/29/60 - 9/24/60 - 103 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 10, 1960 to 9/24, 1960 , that I last saw the deceased alive on 9/24 (2nd) 1960, and that death occurred at 7:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael M. Dobridge		DATE SIGNED 10630 Sergio one Silver Spring 7/24/60	
PHYSICIAN'S NAME (Type) Michael M. Dobridge		ADDRESS (Street, city or town, state) 10620 Georgia Ave. Silver Spg. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/60	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR DATE SEP 26 60	
24b. REGISTRAR'S SIGNATURE Charles S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT.

10445

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10491

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person is necessary, it is necessary to have the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if instit. and Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolsville	
c. LENGTH OF STAY IN lb 2 hrs		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) B & R R track			
3. NAME OF DECEASED (Type or print) Charles Craven	First	Middle	Last
4. DATE OF DEATH Sept 8 19 60	Month	Day	Year
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/16
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ma.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mathew Craven		14. MOTHER'S MAIDEN NAME Lilly I. Driver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration			
DUE TO crushed skull (skull practically decapated)			
DUE TO			
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported walking along R R togo to mens room when struck by train	
20c. TIME OF INJURY Month, Day, Year 9/9/60	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B & O R R	20f. (City or town) (County) (State) Kensington Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/60	
22c. NAME OF CEMETERY OR CREMATORY Seneca		22d. LOCATION (City, town, or country) (State) Seneca, Md.	
23. FUNERAL DIRECTOR Heath L. Lumsden		24a. REC'D BY REGISTRAR SEP 13 '60	
24b. REGISTRAR'S SIGNATURE Robert S. Adams			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10396

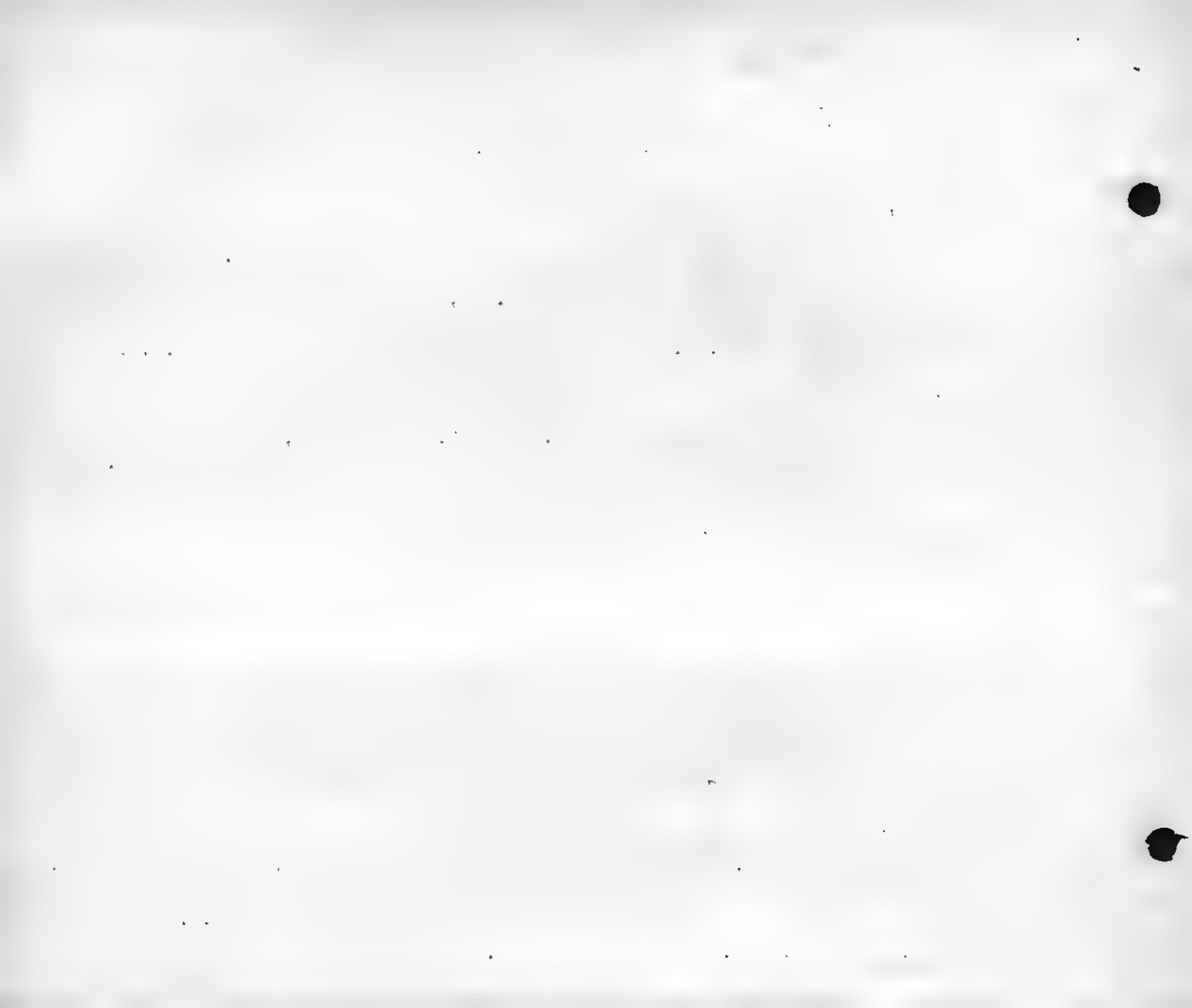
CERTIFICATE OF DEATH

10402

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MA 'YI AND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,943 CLARIDGE ROAD				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIEN Middle JENNIE Last CUMMINGS				4. DATE OF DEATH Month SEPT. Day 25 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 27, 1898		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK GAO (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ORIN J. CUMMINGS				14. MOTHER'S MAIDEN NAME ADELADE CASE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address Mrs. Allen R. Collier, 11,943 Claridge Road Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure +1107 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 124 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 7, 1940 to Sept 25, 1960 , that (I) (we) last saw the deceased alive on Sept 24, 1960 , and that death occurred at 3 AM , from the causes and on the date stated above.							
22a. SIGNATURE W B Wardrop MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/26/60	
22c. PHYSICIAN'S NAME (Type) WILLIAM B. WARDROP				22d. ADDRESS 800 PERSHING DRIVE, SILVER SPRING, MD.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/27/60		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond W. Gustaf				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE SEP 29 '60	
				25b. REGISTRAR'S SIGNATURE Charles E. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL: The attending physician: The low requires that the death certificate be secured within 24 hours after death. Page 4, may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any
please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Burial Permit
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

10455
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
104103
10455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN TB <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MONOGAHELA</u> <u>11515 Montgomery Rd. Rockville, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>MONOGAHELA</u> <u>11503 Montgomery Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Michael Joseph Danaher</u> First Middle Last 4. DATE OF DEATH <u>Sept 13 1960</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-1-60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gerald J. Danaher</u>		14. MOTHER'S M maiden NAME <u>Caroline Hormain</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u> (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>G. J. Danaher (father)</u> Address <u>Item 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in crib</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald J. Brosch</u> EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Zucka</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '60</u> DATE 24b. REGISTRAR'S SIGNATURE <u>William S. Knecht</u>	

104755

CERTIFICATE OF DEATH

Reg. Dist. No.

10404

1. PLACE OF DEATH a. COUNTY Montg.		2. USUAL RESIDENCE (Where deceased lived. If institution or residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 9 Da	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montg. Co. General Hospital		e. STREET ADDRESS 1 North Summit Ave	
3. NAME OF DECEASED (Type or print) First James Middle Ernest Last Day		4. DATE OF DEATH Month Sept Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 4-1890
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 6 Days 25 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Painter, Retired		10b. KIND OF BUSINESS OR INDUSTRY Gaithersburg, Md.	
11. BIRTHPLACE (State or foreign country) U & A		12. CITIZEN OF WHAT COUNTRY? U & A	
13. FATHER'S NAME George W. Day		14. MOTHER'S MAIDEN NAME Joana Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1-1919	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular lying cause lost. (c) Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 15, 1960 to Sept. 29, 1960 that I last saw the deceased alive on Sept. 29, 1960 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 105 Russell Ave, Gaithersburg, Md.	
ACTUAL SIGNATURE Jack Schumacher		DATE SIGNED 9-29-60	
PHYSICIAN'S NAME (Type) JACK SCHUMACHER M.D.		Gaithersburg, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-2-60	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		ADDRESS Gaithersburg, Md.	
24a. REC'D BY REGISTRAR Oct 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CORONER NOTIFIED AND RELEASED

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
10476										
10405										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>4 hrs.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					e. STREET ADDRESS <u>1005 N.W. Adams St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Nell</u> Middle <u>Graham</u> Last <u>Day</u>					4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7, 1932</u>		9. AGE (In years last birthday) <u>28</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plastic dishes</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nemir Industries</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John T. Little</u>					14. MOTHER'S MAIDEN NAME <u>Elva Prater</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Yes-Unknown</u>		17. INFORMANT (Husband) <u>Norman Day</u>			Address <u>Rt. 1 - Gaithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Herniation of Brain Stem</u> DUE TO <u>Intracerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 hours</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5:45 PM</u> 19 <u>9/26/60</u> and that death occurred at <u>10:30 PM</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Richard C. Myers</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD C. MYERS</u>					22d. ADDRESS <u>8512 Old Georgetown Rd. Bz.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>					ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

(M)

X

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
10406											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyer</u>				c. LENGTH OF STAY IN 1b <u>life</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyer</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Boyer</u>				d. STREET ADDRESS <u>Boyer</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Baker Daymude</u>				4. DATE OF DEATH <u>Sept 28</u> 19 <u>60</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>2-26-95</u>		9. AGE (In years last birth day) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u>28</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u>28</u> Min. <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mail carrier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>				11. BIRTHPLACE (State or foreign country) <u>md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.E</u>				13. FATHER'S NAME <u>Geo. Daymude</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Mae Nicholson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>1915-1919 U.S. Marines</u>				17. INFORMANT <u>Patty Nicholson - Boyer md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)											
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Bronchopneumonia</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>9-28-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>Boyer Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boyer Presbyterian</u>		22d. LOCATION (City, town, or country) (State) <u>Md.</u>					
23. FUNERAL DIRECTOR <u>Constance C. Shelton</u>				24a. REC'D BY REGISTRAR <u>Barneville, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

ATTENDING PHYSICIAN: The law requires that the body may be returned by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit certificate and submitted to the State Board of Health prior to burial, cremation, or reinterment.

10456 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10408

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1 please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1102 Parviz Dr</u>		d. STREET ADDRESS <u>1102 Parviz Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Inez Dodd</u>	4. DATE OF DEATH <u>Sept 10 1960</u>	e. 5. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1933</u>
9. AGE (In years last birthday) <u>27</u> yrs.	10. IF UNDER 1 YEAR <u>5</u> Months <u>8</u> Days	11. IF UNDER 24 HRS. <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Ind</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Samuel Hunter</u>	14. MOTHER'S MAIDEN NAME <u>Mayhew</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Arac Dodd (husband)</u>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>974X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Strangling</u> DUE TO <u>Asphyxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Hung self in attars of her home</u>		
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>	
24b. REGISTRAR'S SIGNATURE <u>SEP 14 '60</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10403

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville Park</i>	c. LENGTH OF STAY IN 1b <i>4 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Anne Hospital</i>		d. STREET ADDRESS <i>1006 Orchard Way</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Stephen Arnold Douglas</i>		4. DATE OF DEATH Month Day Year <i>9 1 1960</i>	
5 SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-12-83</i>
9. AGE (In years lost birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Jeweler (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tiffanys Jewelry</i>	11. BIRTHPLACE (State or foreign country) <i>Nebraska</i>
12. CITIZEN OF WHAT COUNTRY? <i>America</i>		13. FATHER'S NAME <i>Isaac Douglas</i>	
14. MOTHER'S MAIDEN NAME <i>Annie Brenton</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>056-10-1788</i>		17. INFORMANT <i>p't Hosp Record</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X Invasive Heart Failure</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>CARCINOMA OF STOMACH</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1-2 yrs</i> <i>2-3 yrs</i> <i>2 years</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Nutritional Cirrhosis of Liver</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>1955</i> to <i>Sept 2</i> , 1960 that (I) (we) last saw the deceased alive on <i>Sept 1</i> , 1960, and that death occurred at <i>6:30</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert B. Iney</i>		22b. DATE SIGNED <i>9-2-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT B. INEY</i>		22d. ADDRESS <i>7105 Pop Rd. Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>9/6/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CREMATORY</i>		23d. LOCATION (City, town, or county) (State) <i>PRINCE GEO. COUNTY, MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wagner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 7 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			



TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

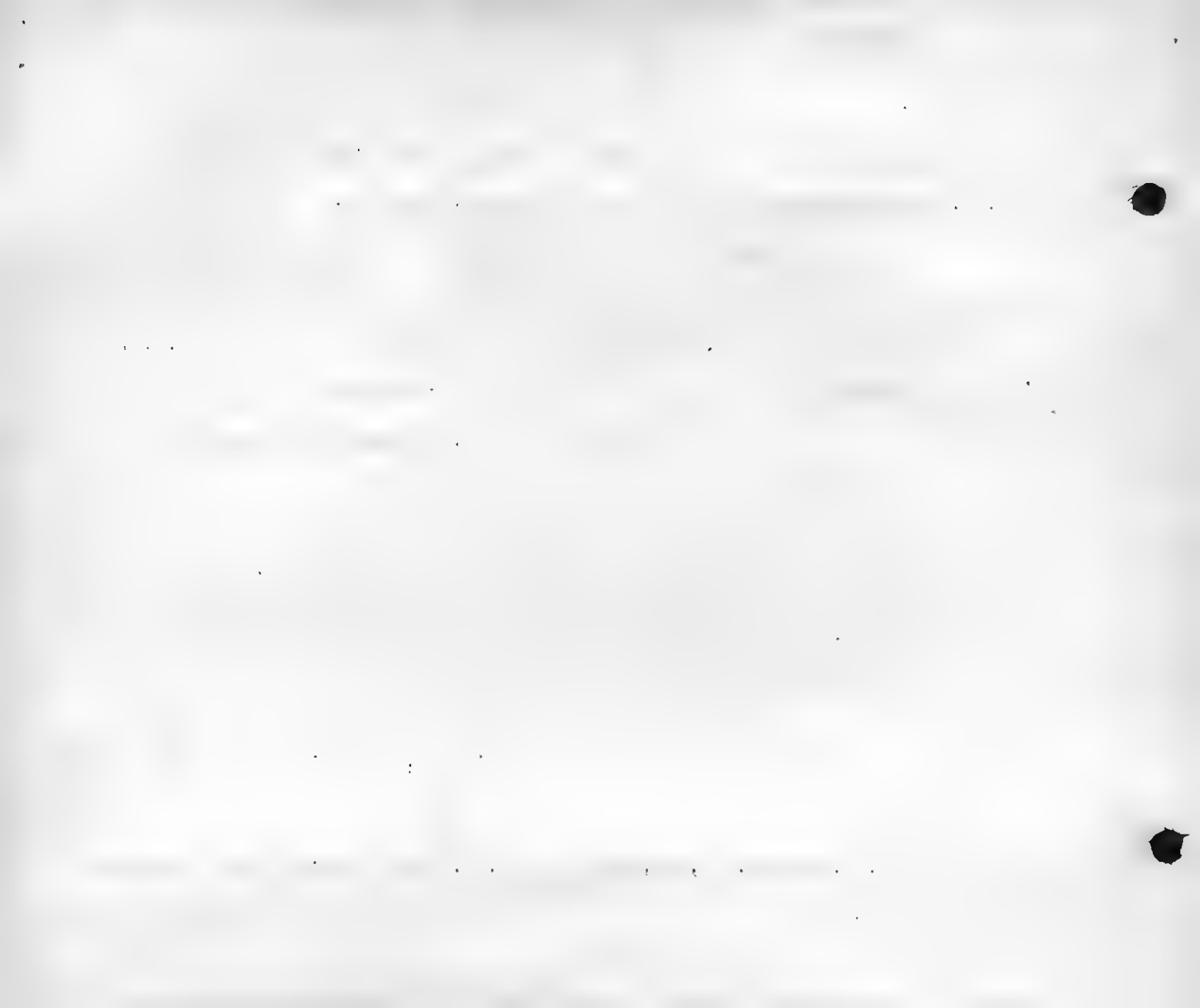
(M)

10478

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10410

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE FLORIDA FLORIDA b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Green Cove Springs		48X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 734 N. Pine Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Nazarine Middle DOWDEN Last DOWDEN		4. DATE OF DEATH Month September Day 28 Year 19 60	
5 SEX Female	6. COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-11
9. AGE (In years last birthday) 49 yrs		IF UNDER 1 YEAR Months 4 Days 8 Hours 2 Min 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11 BIRTHPLACE (State or foreign country) Georgia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace CHAMBERS		14. MOTHER'S MAIDEN NAME Alberta HECKNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 264-16-3108	
17 INFORMANT (H) Edw. J. Dowden, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respirator Arrest DUE TO Brain metastases of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sq Cell Carcinoma Cervix Uteri (c) Squamous Cell Carcinoma metastatic to lungs		INTERVAL BETWEEN ONSET AND DEATH 1 yrs 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous Cell Carcinoma metastatic to lungs		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (do not) attended the deceased from Sept. 17 19 60 to Sept. 28 19 60 that (I) (was) last saw the deceased alive on Sept. 28 19 60 , and that death occurred at 10:50AM M, from the causes and on the date stated above		22a SIGNATURE R. F. MADING M D 22b DATE SIGNED 9-28-60	
22c PHYSICIAN'S NAME (Type) R. F. MADING, LT, MC, USN		22d ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-29-60		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY Green Cove Springs Florida		23d LOCATION (City, town or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE Robert Snowden Funeral Home, Rockville, Md.		25a REC'D BY REGISTRAR DATE SEP 30 '60	
25b REGISTRAR'S SIGNATURE Arthur S. House			



MARYLAND STATE DEPARTMENT OF HEALTH

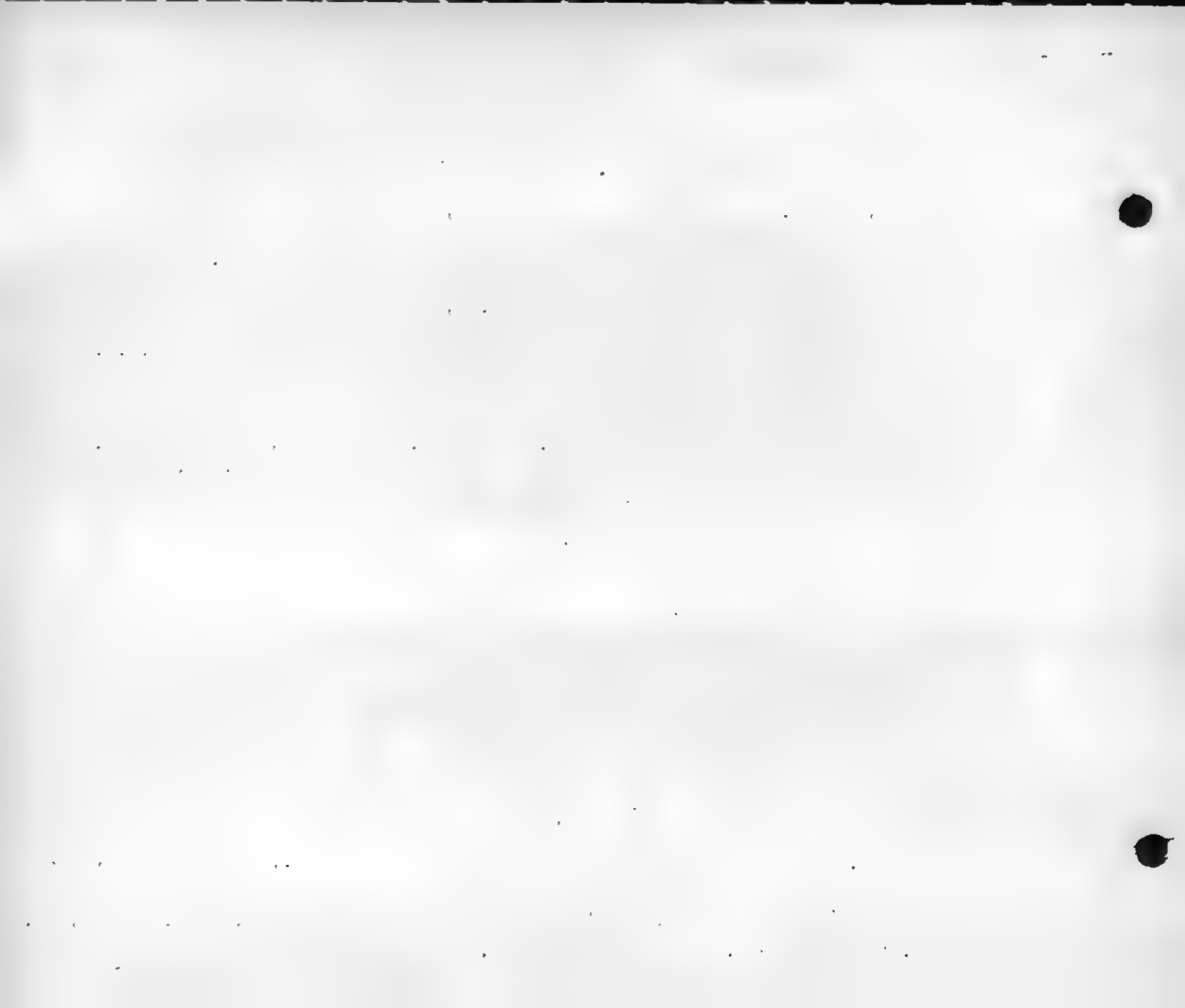
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10398

CERTIFICATE OF DEATH

10411

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 19 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 10,604 LORAIN AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,604 LORAIN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last NELLIE GERTRUDE DUNBAR		4. DATE OF DEATH Month Day Year SEPT. 25 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 4, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HONORARY		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CORNELIUS WHELAN		14. MOTHER'S MAIDEN NAME ALICE BLANCHFIELD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Richard C. Dunbar, 10,604 Lorain Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 44° X DUE TO		Silver Spring, Md. INTERVAL BETWEEN ONSET AND DEATH 30 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) 30 min	
(c) 7.		7.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 4/26 1950 to 9/25/60 19 that (I) (we) lost saw the deceased alive on 9/21 1960, and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Marion Bankhead M.D.		22b. DATE SIGNED 9/25/60	
22c. PHYSICIAN'S NAME (Type) J. MARION BANKHEAD		22d. ADDRESS 9421 Columbia Blvd., Silver Spring, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/29/60	
23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION (City, town, or county) (State) FOREST GLEN, MONT. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Marion Bankhead, INC.		25a. REC'D BY REG-STRAR DATE SEP 30 '60	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN

21 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2510 Briggs Chaney Rd

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

md

b. COUNTY

Montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

12510 Briggs Chaney Rd

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Bessie Banks Duwall

4. DATE OF DEATH

9-13-60

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

WIDOWED ☒ NEVER MARRIED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-28-1896

9. AGE (In years last birthday)

64 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF WHAT COUNTRY?

U.S.C.

13. FATHER'S NAME

James Frank Woodward

14. MOTHER'S MAIDEN NAME

Mary E. Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

Frank W. Duwall (son)

17. INFORMANT

Address 2600 Briggs Chaney Rd Silver Spring, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

174X IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Apoplexy
Hanging

INTERVAL BETWEEN ONSET AND DEATH

suicide

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Bloeschant

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9-13-60

EXAMINER'S NAME (Type)

FRANK J. Bloeschant

Address (Street, city, town, or county)

22b. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22c. DATE THEREOF

Sept 16, 1960

22d. NAME OF CEMETERY OR CREMATORY

Union Cemetery

22e. LOCATION (City, town, or country)

Burtonsville, Md.

(State)

23. FUNERAL DIRECTOR

Arthur Walters, 254 Carroll St NW SE

ADDRESS

24a. REC'D BY REGISTRAR

DATE SEP 15 '60

24b. REGISTRAR'S SIGNATURE

Charles S. Kraus

10400

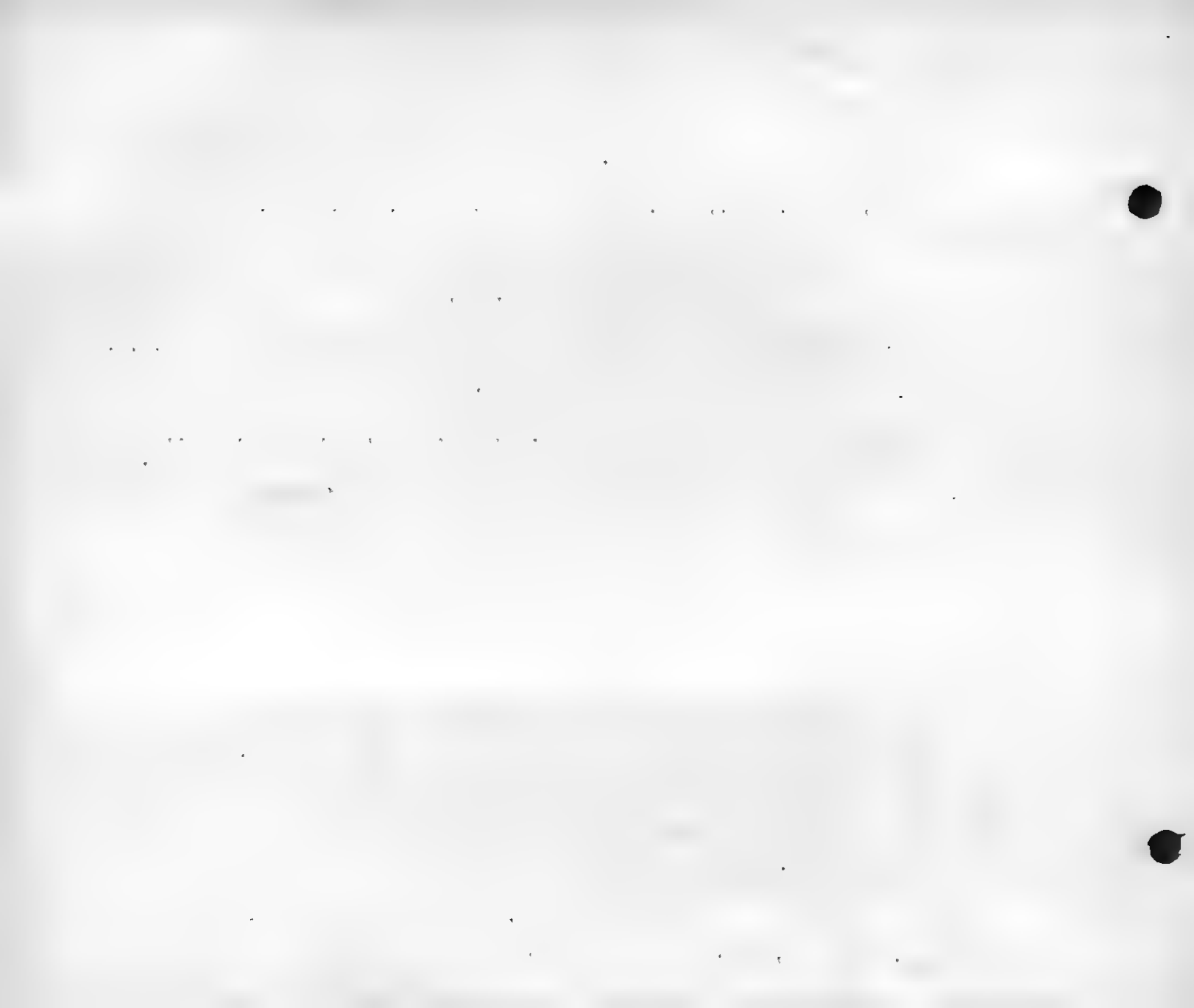
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10413

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 SILVER SPRING	
c. LENGTH OF STAY IN 1b 3 yrs.		d. STREET ADDRESS 10,102 Ga. Ave., Apt. #102	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,102 Ga. Ave., Apt. #102		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Benedict Dyer		4. DATE OF DEATH Month Day Year Sept 24 1960	
5. SEX MAL	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1891
9. AGE (in years last birthday) yrs 68		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY WABASH RAILROAD	
11. BIRTHPLACE (State or foreign country) TOPEKA, KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD P. DYER		14. MOTHER'S MAIDEN NAME ELLEN MCCARTHY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW #1		16. SOCIAL SECURITY NO None	
17. INFORMANT Address Mrs. Mary J. Dyer, 10,102 Ga. Ave., Silver Spring, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Occlusion DUE TO (b) Coronary Artery Insufficiency DUE TO (c) Coronary Artery Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 2 hrs 1 day 5 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —		20c. TIME OF INJURY Month, Day, Year Hour am p. m. 19	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —		(County) —	
(State) —		21. I certify that (I) (this hospital) attended the deceased from 24 Sept 1960 to 24 Sept 1960 that (I) (we) last saw the deceased alive on 24 Sept 1960 and that death occurred on 24 Sept 1960 at 8:55 PM from the causes and on the date stated above.	
22a. SIGNATURE Merton L. White		22b. DATE SIGNED 24 Sept 60	
22c. PHYSICIAN'S NAME (Type) MERTON L. WHITE		22d. ADDRESS 11134 Georgia Ave, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/27/60	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond W. Givens		25a. REC'D BY REGISTRAR DATE SEP 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS SILVER SPRING, MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10414

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown, R-2 c. LENGTH OF STAY IN 15 MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Berryville Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown, R-2 d. STREET ADDRESS Berryville Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence Elizabeth Prather Dyson First Middle Last 4. DATE OF DEATH Sept 13 19 60 Month Day Year		5. SEX female 6. COLOR OR RACE col. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 6/19/16 9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Prather 14. MOTHER'S MAIDEN NAME Bertha Draper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mary Prather (sister) Address Item 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 9/13/60 DATE SIGNED	
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/16/60 22c. NAME OF CEMETERY OR CREMATORY Poolersville, 22d. LOCATION (City, town, or country) (State) Poolersville, Md.		23. FUNERAL DIRECTOR Robert L. Surden ADDRESS Rockville, Md. 24a. REC'D BY REGISTRAR SEP 19 '60 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

MEDICAL CERTIFICATION

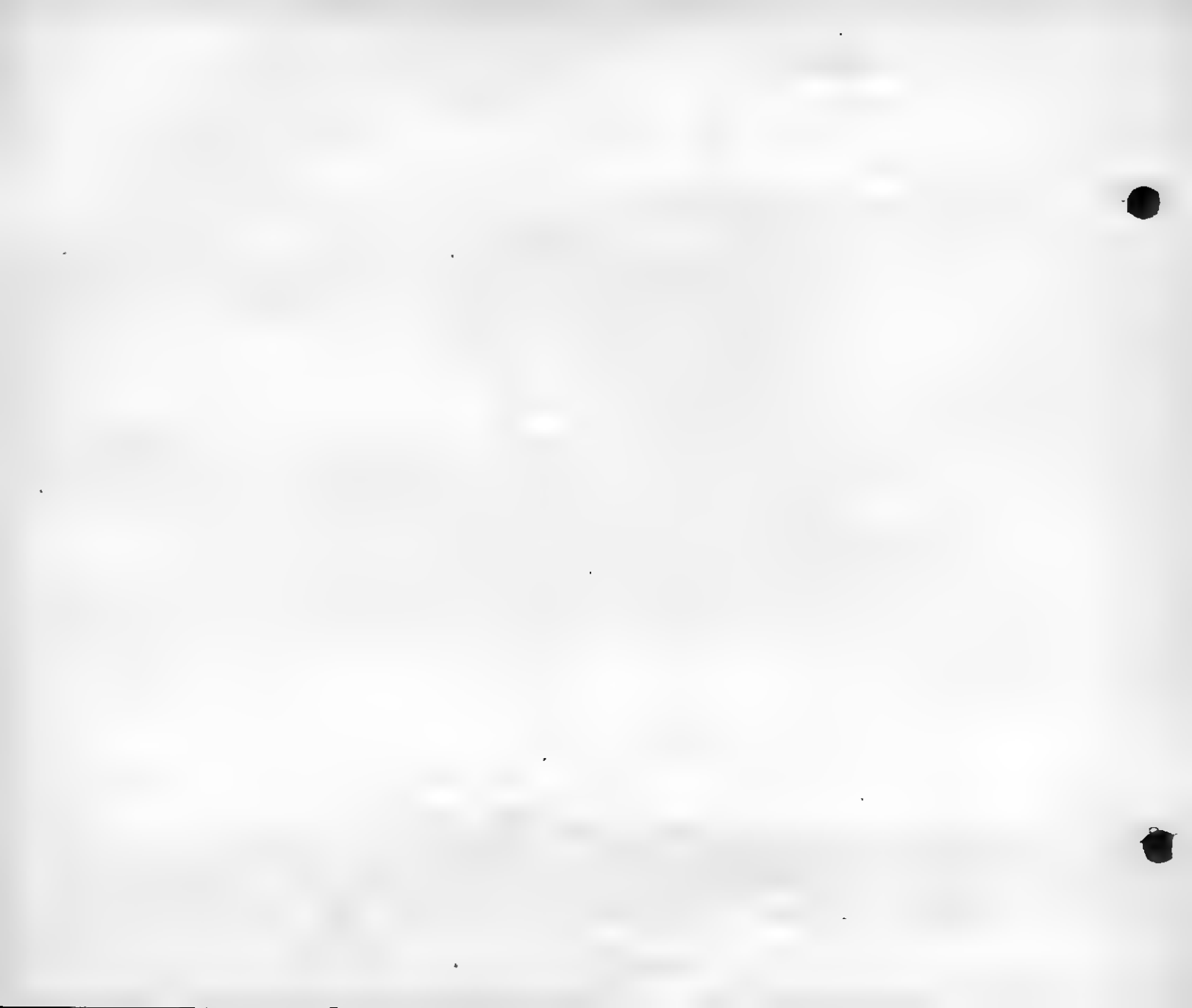


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10415

10480

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Adams</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clayton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>—</u>	
3 NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>B. Ellerbrock</u> Last <u>—</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1960</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Clayton, Ill.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>James Jefferson</u>		14 MOTHER'S MAIDEN NAME <u>Sarah C. Foster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT <u>Mrs. Eva Kaufmann Olney-Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebotrombosis of Femoral at 15 min</u> DUE TO (c) <u>Sen. art. Sclerosis + Debility</u> 10 yrs		INTERVAL BETWEEN ONSET AND DEATH <u>2 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVE IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>3-9</u> , 19 <u>59</u> to <u>13 Aug</u> , 19 <u>60</u> ; that (I) (we) last saw the deceased alive on <u>13 Aug</u> , 19 <u>60</u> and that death occurred at <u>10:15</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John Bosley Ziegler</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>		22d. ADDRESS <u>Olney Md.</u>	
23a BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE THEREOF <u>9-17-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clayton, Illinois</u>	23d. LOCATION (City, town, or county) (State) <u>Clayton, Illinois</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		25a REC'D BY REGISTRAR <u>SEP 15 '60</u>	25b REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>



10481

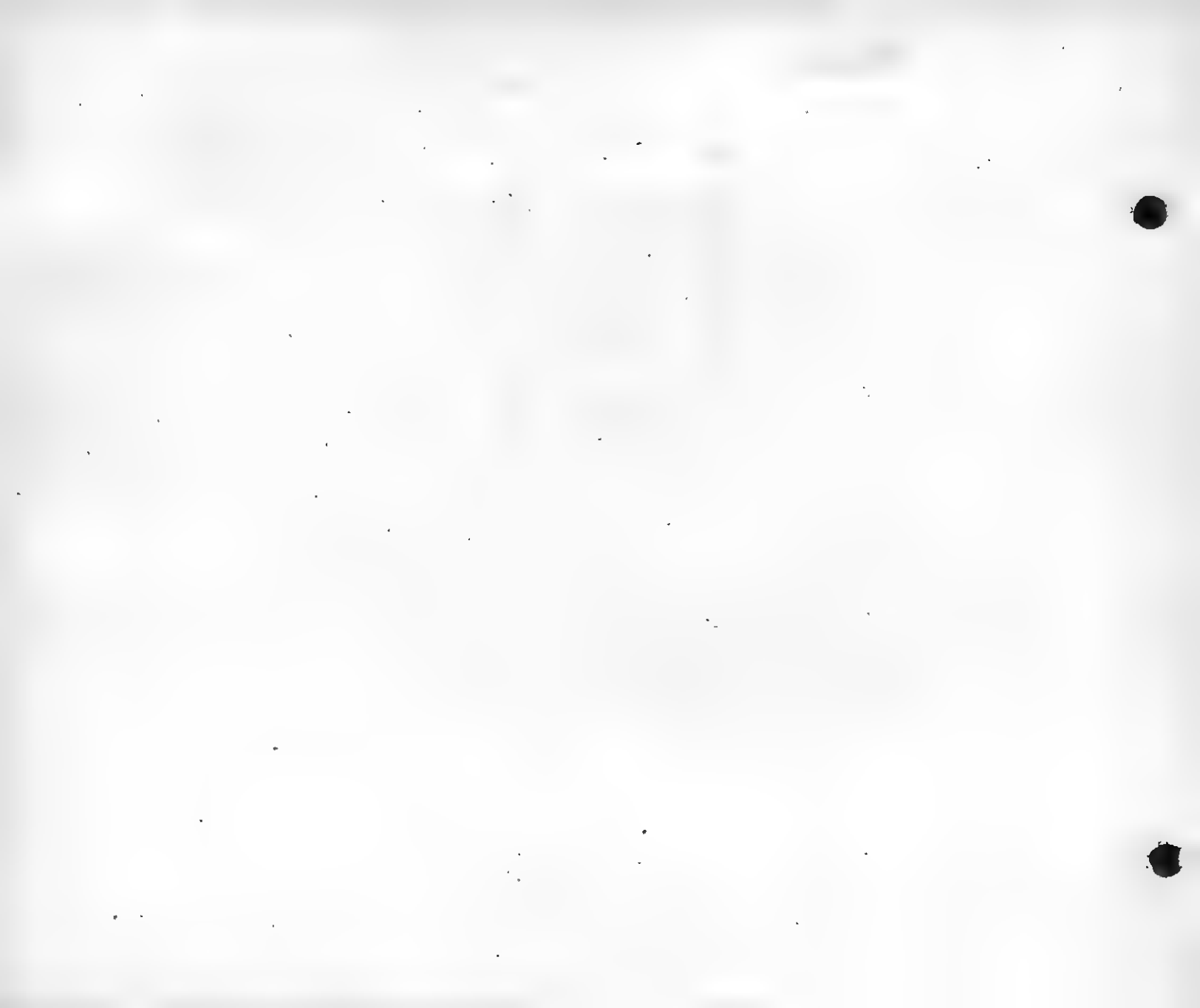
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>RURAL Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKDALE, MD.</u>	
c. LENGTH OF STAY in 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>		d. STREET ADDRESS <u>4707 Overbrook Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Georgia</u> First <u>G.</u> Middle <u>Ellis</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1880</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis, Mo.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE POOLE</u>		14. MOTHER'S MAIDEN NAME <u>WOLF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> Semic DUE TO (c)		18. INTERNAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June, 1959</u> , to <u>Sept 17, 1960</u> , that I last saw the deceased alive on <u>9-17</u> , 1960 and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. P. Andrews M.D.</u> M.D. <u>4201 Fessenden St. N.W. Washington, D.C.</u>		DATE SIGNED <u>9-17-60</u>	
PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 20 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Humes</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



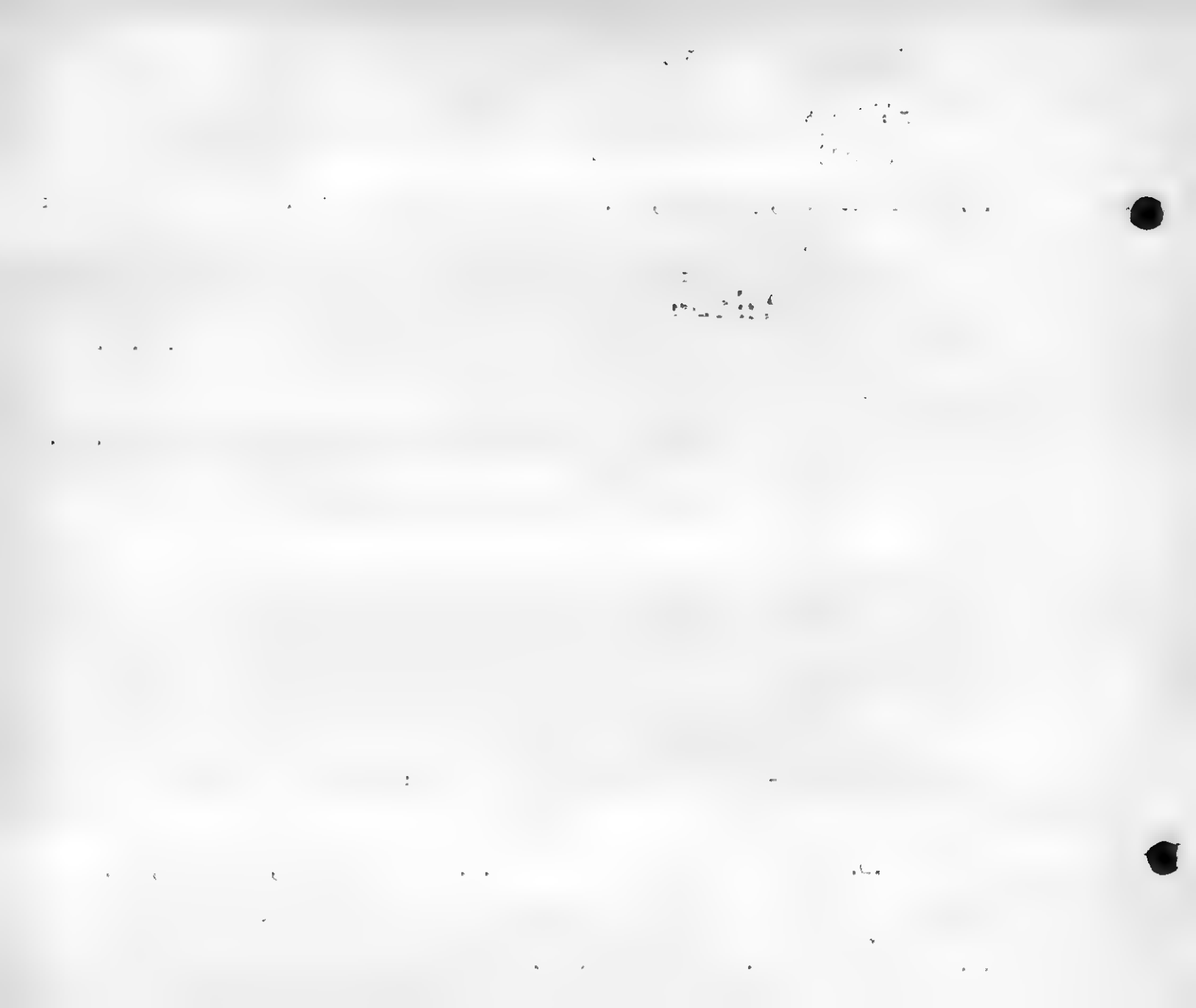
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
10482
M
5
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10417

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 11100 Griffing Blvd.	
3. NAME OF DECEASED (Type or print) First Corinne Middle Ellis Last FAILING		4. DATE OF DEATH Month September Day 10 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-96
9. AGE (In years last birthday) yrs 64		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Ellis		14. MOTHER'S MAIDEN NAME Louise House	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Rollin Failing		Address 11100 Griffing Blvd Miami, Fla.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral vascular collapse 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post OPERATIVE SEPSIS & PYELONEPHRITIS & PNEUMONIA DUE TO (c) Extensive carcinoma urinary bladder		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-25 19 60 to 9-10-60 19 that (I) (we) last saw the deceased alive on 9-10 19 60 , and that death occurred at 8:25 PM on the causes and on the date stated above.			
22a. SIGNATURE J. D. Real		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J.D. REAL LT MC USN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9-14-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		25a. REC'D BY REGISTRAR SEP 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in 27, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10418

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>24 hours.</u>		d. STREET ADDRESS <u>9301 Weaver St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Estella</u> Middle <u>M</u> Last <u>Figgins</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1960</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-73</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>American - D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thomas Sewell</u>		14. MOTHER'S MAIDEN NAME <u>Estella Hear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Thomas S. Israel</u>		Address <u>S.S. Md. 10304 Inwood Ave.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute Dilatation (acute)</u> (c) <u>Early Broncho pneumonia + pulm Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6 hrs</u> <u>"</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diagnosed Arteriosclerosis; Carcinoma Breast</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> 19 <u>60</u> to <u>Sept 17</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Sept 17</u> 19 <u>60</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above			
22a SIGNATURE <u>Raymond O. West</u> M.D.		22b DATE SIGNED <u>Sept 18/60</u>	
22c PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>		22d ADDRESS <u>7600 Carver Ave, Takoma Park</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>9/21/1960</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co.-2901 14th St. N.W.</u>		25a REC'D BY REGISTRAR <u>SEP 20 '60</u>	
ADDRESS <u>Washington 9, D.C.</u>		25b REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10419

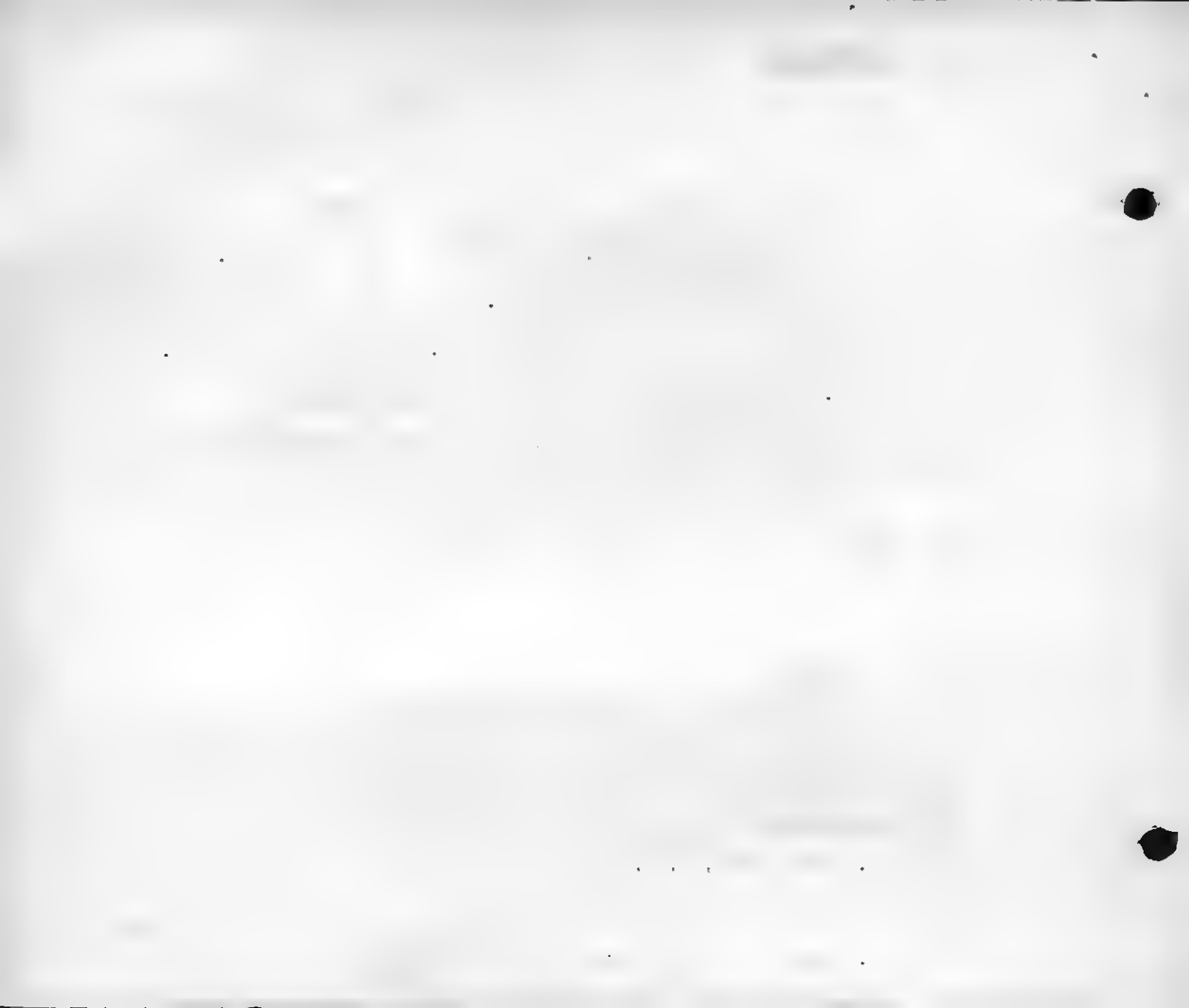
Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda-Poolesville D.O. A.</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Poolesville Route #107</u> <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> d. STREET ADDRESS <u>Route # 107</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Infant</u> <u>Boy</u> <u>Fisher</u> First Middle Last 4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1960</u>			5. SEX <u>Male</u> 6. COLOR OR RACE <u>colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 25, 1960</u> 9. AGE (In years last birthday) <u>3</u> IF UNDER 1 YEAR <u>3</u> IF UNDER 24 HRS <u>3</u> Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mont. Co.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Barnes</u>			14. MOTHER'S MAIDEN NAME <u>Frances Fisher</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother's Chart,</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> DUE TO <u>Birth Trauma</u> (b) <u>Prematurity</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/26/60</u>				
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>			
22d. LOCATION (City, town, or county) <u>Rockville, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Semaden</u> ADDRESS <u>Rockville, Md.</u>					
24a. REC'D BY REGISTRAR DATE <u>Oct 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 10484
 CERTIFICATE OF DEATH

10421

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>3hrs. 45min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Foreman</u>		4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 10, 1960</u>
9. AGE (In years lost birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Foreman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Budd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO <input type="checkbox"/>	
17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease</u> (b) <u>Interventricular defect</u> (c) <u>atelectasis of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVentricular defect</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> 19 <u>60</u> , to <u>9/13</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/13</u> 19 <u>60</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gilcin F. Meadors, MD.</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Gilcin F. Meadors, MD.</u>		22d. ADDRESS <u>Damascus, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/13/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Cynthia L. Thomas</u>	

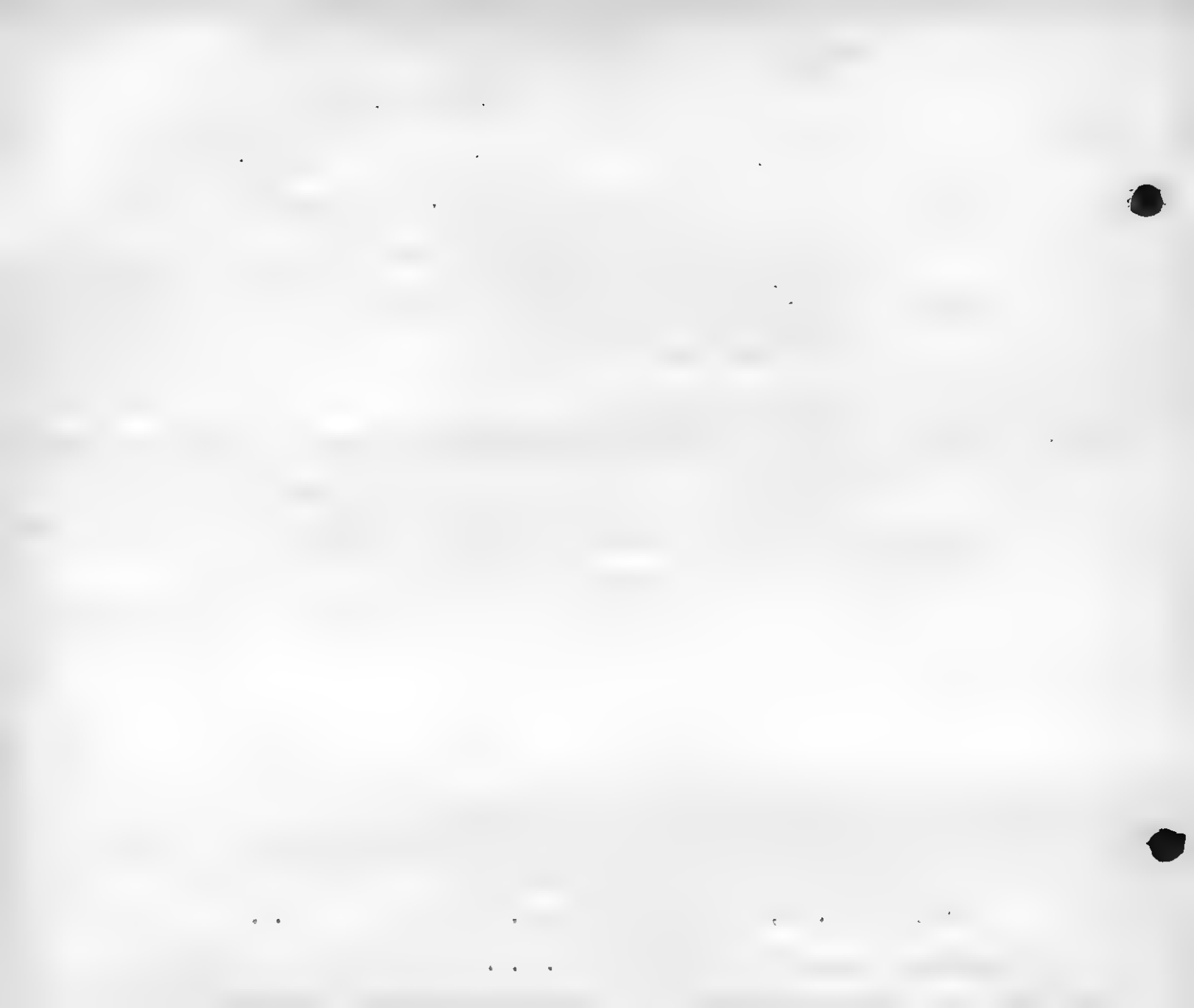


TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 20 Film 271 9-20-60 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10401 CERTIFICATE OF DEATH

10422

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2311 WEST VIEW DRIVE		d. STREET ADDRESS 2311 WEST VIEW DRIVE	
3. NAME OF DECEASED (Type or print) First ROSE Middle H. FRIEDMAN Last		4. DATE OF DEATH Month 9 Day 22 Year 1960	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APR. 8 - 1891
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW YORK		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME MICHAEL HAMERMAN (DEC.)		14. MOTHER'S MAIDEN NAME SARAH BELLE KATZ (DEC.)	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16 SOCIAL SECURITY NO NONE	
17 INFORMANT HARRY FRIEDMAN		Address 2311 WESTVIEW DR.	
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Embolization - Pulmonary DUE TO 904.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO Fracture left knee - Recent (c)		INTERVAL BETWEEN ONSET AND DEATH in bed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Silver Spring (County) Montg (State) Md.	
21 I certify that (I) (this hospital) attended the deceased from July 8 19 60 , to Sept 21 19 60 , that (I) (we) ast saw the deceased alive on 9-21 19 60 , and that death occurred at 9:30 A.M. from the causes and on the date stated above			
22a. SIGNATURE David J. Vosper M.D.		22b. DATE SIGNED 9-22-60	
22c. PHYSICIAN'S NAME (Type) DAVID J. VOSPER M.D.		22d. ADDRESS 3810 Blackhawk Dr. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL Specify Burial		23b. DATE THEREOF Sep. 26, 1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town, or county) (State) D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Lesley Turner		25a. REC'D BY REGISTRAR SEP 26 '60	
ADDRESS 4217 9th St. N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from the papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10423

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>905 Domes Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>ACE</u> Middle <u>Eugene</u> Last <u>Gleyzal</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-72</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chex</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>France</u>	
11. BIRTHPLACE (State or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>France</u>	
13. FATHER'S NAME <u>Louis Gleyzal</u>		14. MOTHER'S MAIDEN NAME <u>Augustine Mantelin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral & pulmonary edema</u> DUE TO (b) <u>Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma, fibrosis of tongue</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>slap</u> <u>month</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>5-6 1960</u> to <u>9-3 1960</u> , that (I) (we) last saw the deceased alive on <u>9-3 1960</u> , and that death occurred at <u>2:30</u> p.m., from the causes and on the date stated above.			
22a. SIGNATURE <u>Abraham W. Davis</u>		22b. DATE SIGNED <u>9-4-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DAVIS</u>		22d. ADDRESS <u>927 PERSHING DR. S.S.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>Sept. 7-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u> </u>		23d. LOCATION (City, town, or county) (State) <u>Bethesda Md. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walker</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>	
ADDRESS <u>254 Carroll St. NW.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA 15 (4)
15M 9/59

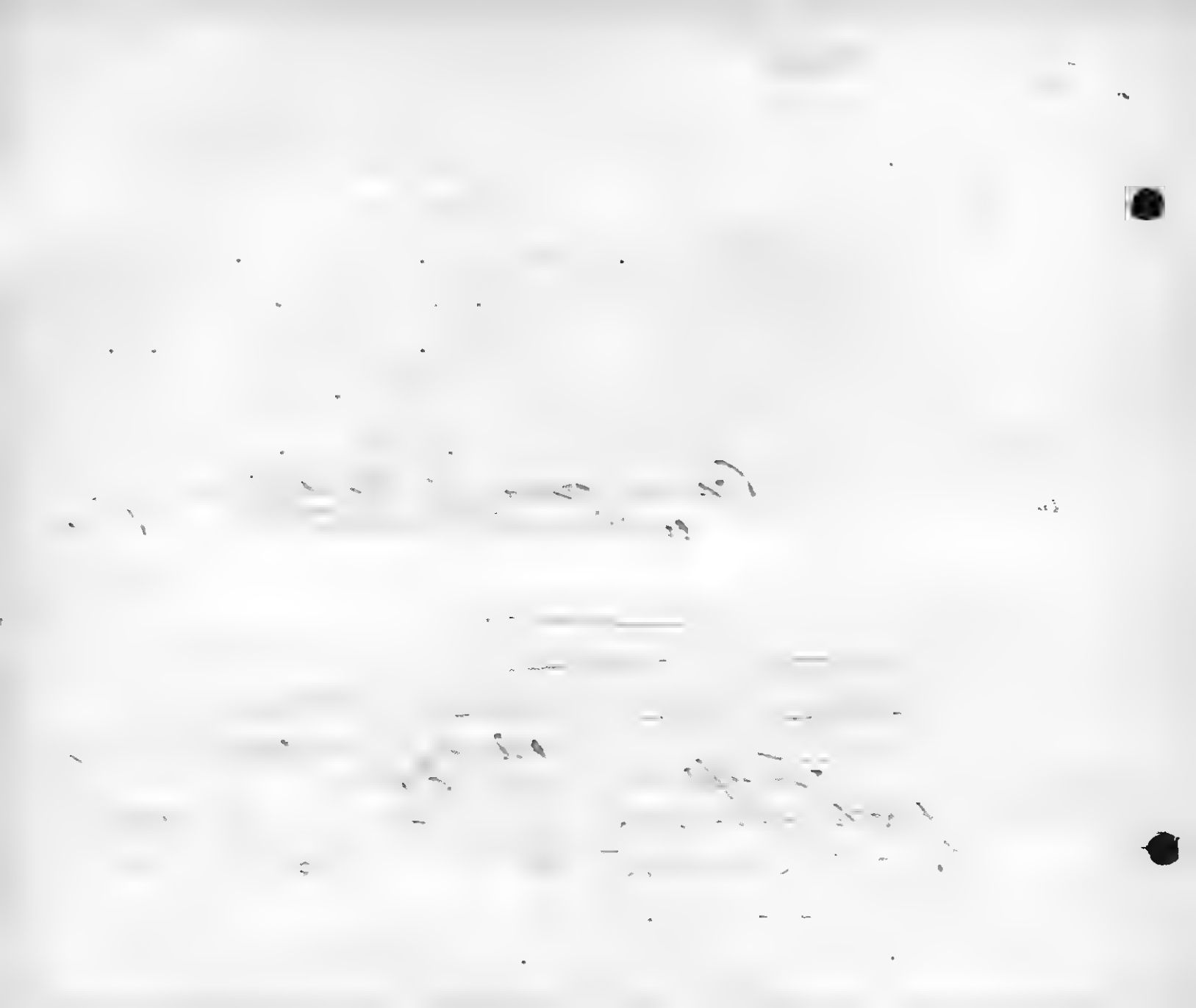
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10485

10424

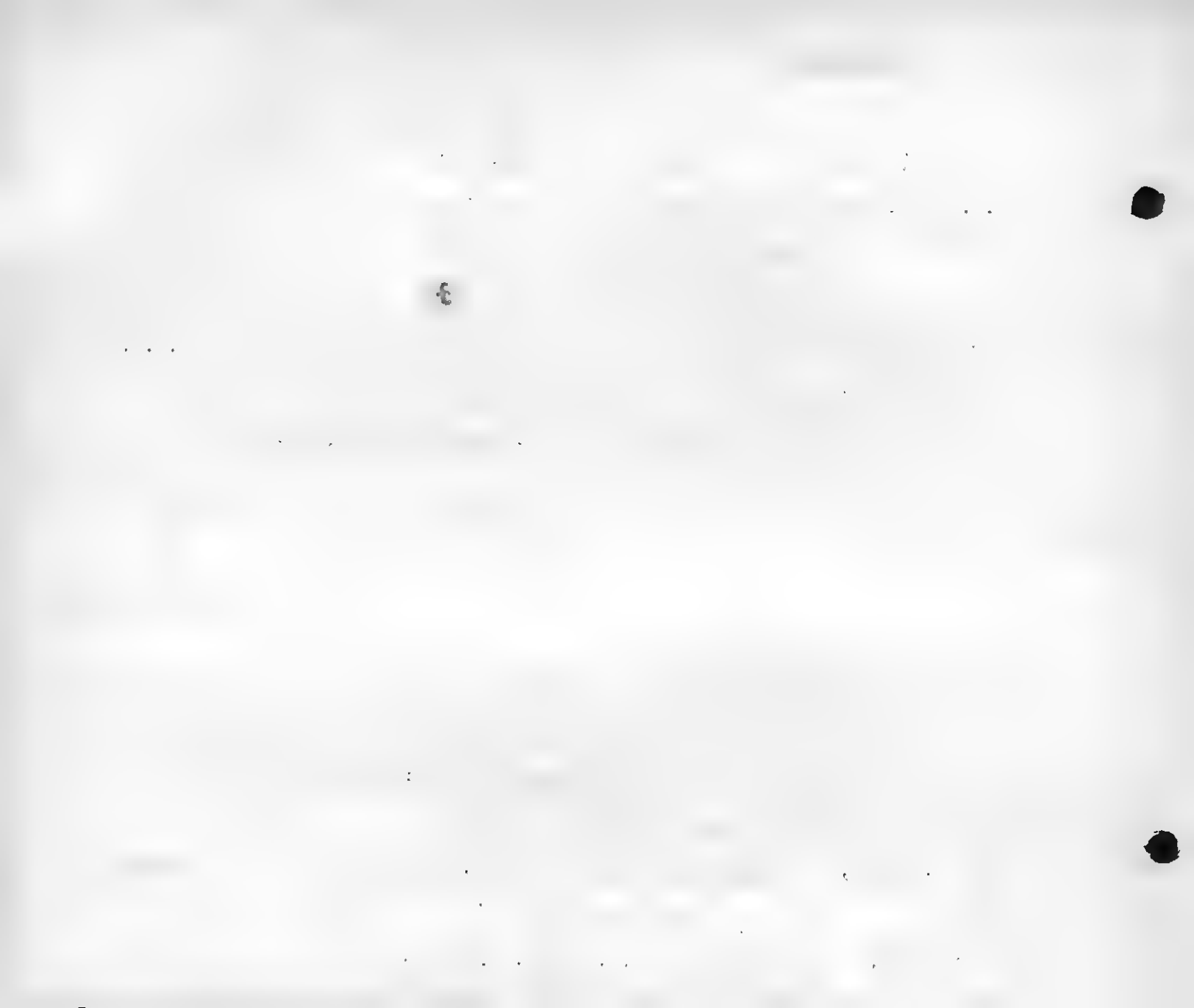
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESMOR SANITARIUM		d. STREET ADDRESS 5309 Burling Terrace	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR E. GOODWIN, Sr.		4. DATE OF DEATH Month Day Year Sept. 23, 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1884
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours Min 8 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Henry Goodwin		14. MOTHER'S MAIDEN NAME Katie M. Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Son		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause not line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Prostate with multiple Metastases DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 60 to 23 Sept 60 , that (I) (we) last saw the deceased alive on 23 Sept 1960 and that death occurred at 10 PM , from the causes and on the date stated above			
22a. SIGNATURE H. RICHWINE, MD		22b. DATE SIGNED 23 Sept 60	
22c. PHYSICIAN'S NAME (Type) H. RICHWINE, MD		22d. ADDRESS 5522 WESTERN AVE CHEVY CHASE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9-24-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) (State) Boston, Mass.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR DATE SEP 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	



10425

10486

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 39 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 530 Riverside Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First David		Middle Raphael		Last GOTTLIEB	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-29	
				9. AGE (In years last birthday) 30 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Israel Davidson GOTTLIEB				14. MOTHER'S MAIDEN NAME Helen Ronald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Mrs. Helen GOTTLIEB, same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-26-60 to 9-1-60 that (I) (we) last saw the deceased alive on 9-1-1960 and that death occurred at 9:35 PM from the causes and on the date stated above							
22a. SIGNATURE L. HINES				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 9-2-60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. HINES, CDR, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-6-60		23c. NAME OF CEMETERY OR CREMATORY Baron Hirsch		23d. LOCATION (City, town, or county) (State) Staten Island, New York	
24. FUNERAL DIRECTOR'S SIGNATURE DANZANSKI				25a. REC'D BY REGISTRAR DATE SEP 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

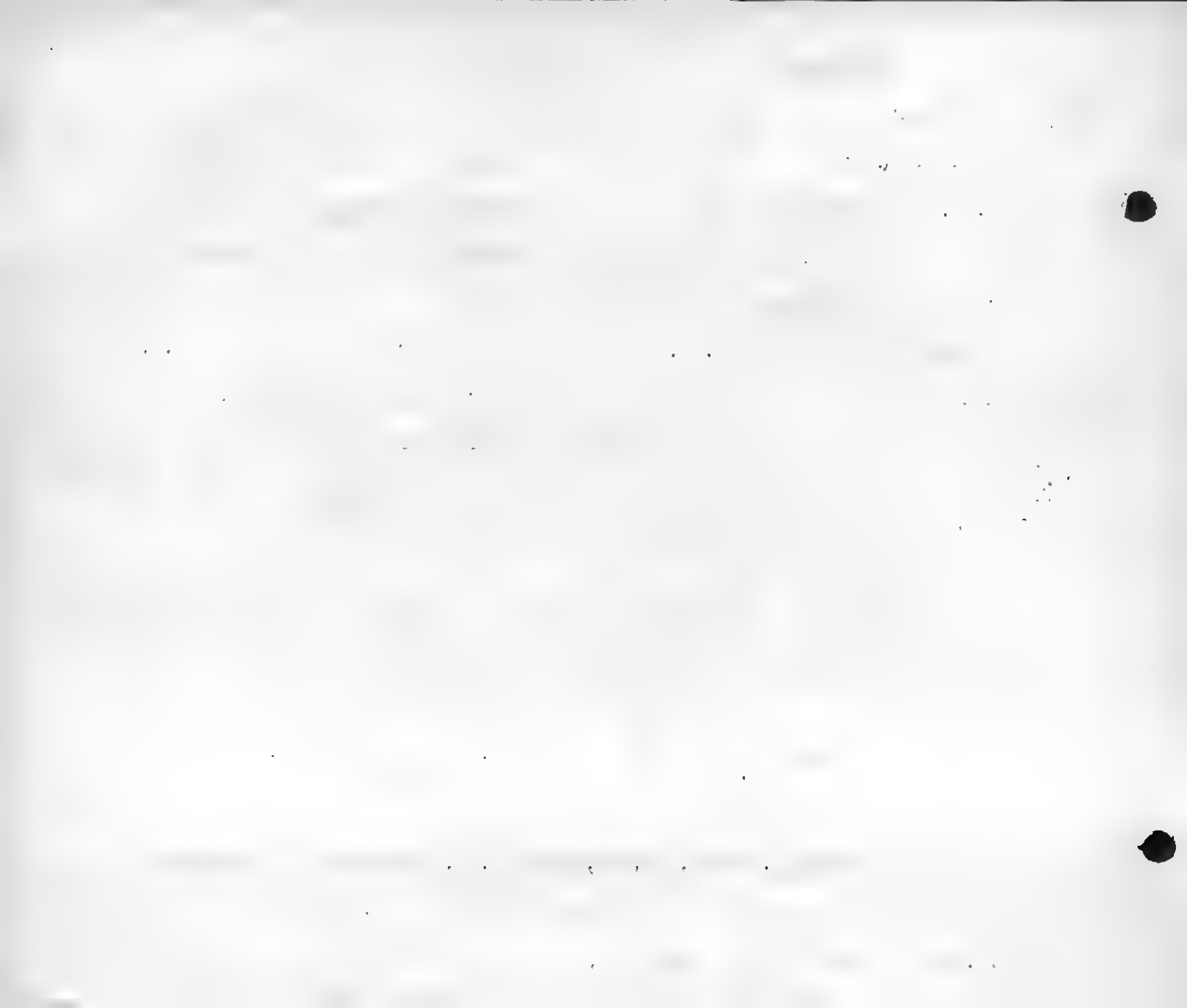
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10426

10487

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Key West			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Sugar Loaf Shores		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Leonidis Last GOULDER				4. DATE OF DEATH Month September Day 24 Year 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-10	9. AGE (In years last birthday) yrs 50	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton GOULDER				14. MOTHER'S MAIDEN NAME Marie Elizabeth (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes 1932 to DOD		16. SOCIAL SECURITY NO. 554-34-1259		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Insufficiency 162 DUE TO metastatic carcinoma of liver & such Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Bronchiogenic carcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from Sept. 20 19 60 to Sept. 24 19 60 that (I) (we) last saw the deceased alive on Sept. 24 19 60 , and that death occurred at 11A AM, from the causes and on the date stated above.							
22a. SIGNATURE William P. Baker				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-25-60	
22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-26-60		23c. NAME OF CEMETERY OR CREMATORY Blandford Cemetery		23d. LOCATION (City, town, or county) (State) Petersburg Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey R.A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE SEP 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10488

10427

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 266 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2014 Gosnell Street			
3. NAME OF DECEASED (Type or print) First Dorothy Middle Sybil Last Grant				4. DATE OF DEATH Month September Day 9 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 30, 1924		9. AGE (In years last birthday) 36 yrs	IF UNDER 1 YEAR Months 36 Days 36 Hours 36 Min 36	IF UNDER 24 HRS Months 36 Days 36 Hours 36 Min 36
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonas A. Hammond				14. MOTHER'S MAIDEN NAME Ira B. Lyon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Choriocarcinoma DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a m. _____ p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from December 18, 19 59 to September 9, 19 60 that (I) (we) last saw the deceased alive on September 9, 19 60 , and that death occurred at 4:01 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Martin Nydick</i>				22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
22c. PHYSICIAN'S NAME (Type) Martin Nydick, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEP 12 1960		23c. NAME OF CEMETERY OR CREMATORY TRUMP TEXAS		23d. LOCATION (City, town, or county) (State) TRUMP TEXAS	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kiser</i>				25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kiser</i>	

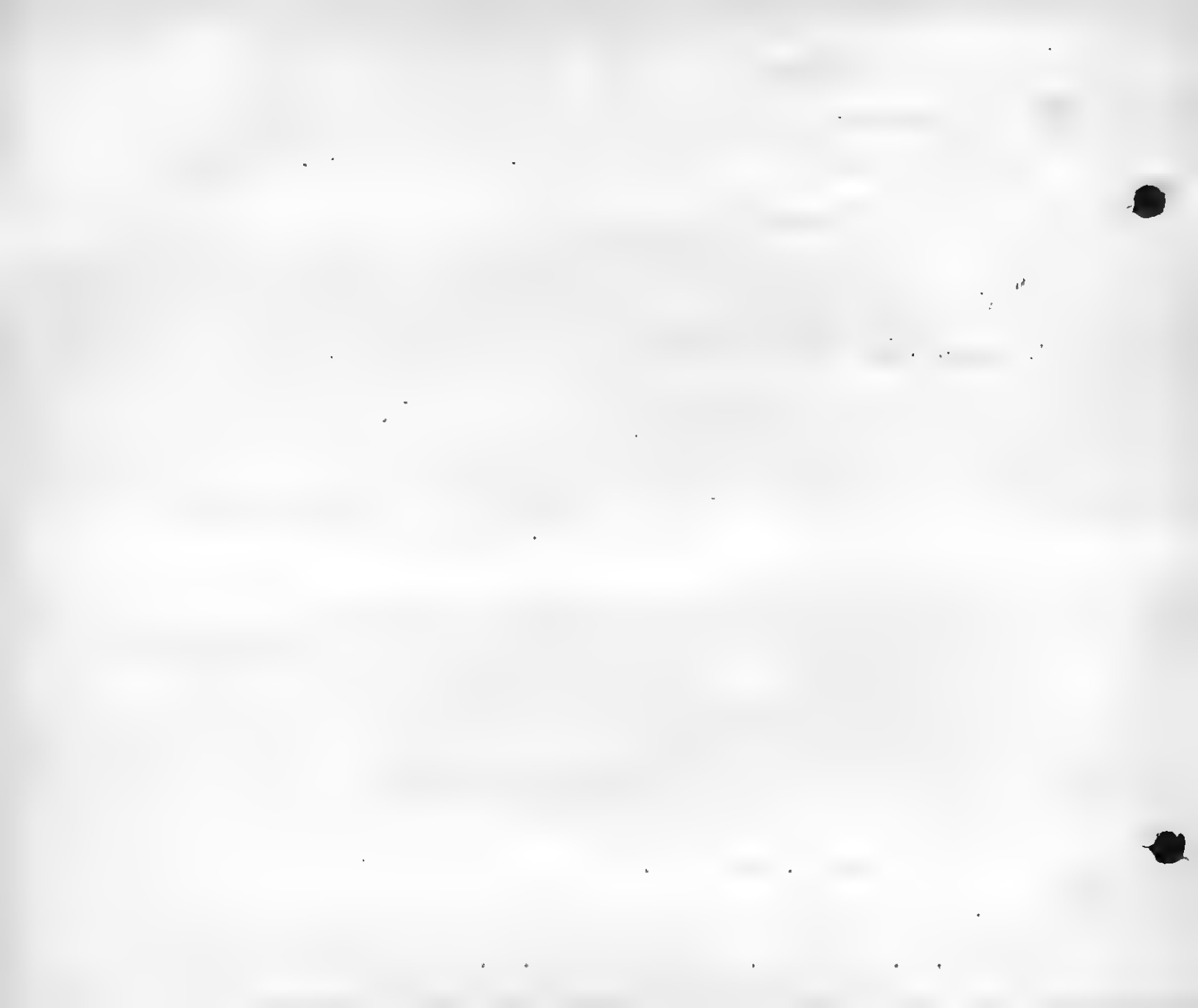
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10428

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 40"</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4201 Mass. Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Emerson</u> Last <u>Greer</u>		4. DATE OF DEATH* Month <u>Sept</u> Day <u>27</u> Year <u>1960</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 26 1891</u>
9a. AGE (In years last birthday) <u>68</u> yrs.		9b. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Rep. ANKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Robert Greer</u>		14. MOTHER'S MAIDEN NAME <u>Ida Sherwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, (If yes, give war or dates of service) <u>Yes, War I</u>		16. SOCIAL SECURITY NO. <u>577-03-5844</u>	
17. INFORMANT <u>wife</u> Address <u>Same as above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>45 IX</u> DUE TO <u>Rupture of atherosclerotic aneurysm, abdom.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u>		(c) <u>not abrtg</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 27, 1960</u> to <u>Sept 27, 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 27, 1960</u> and that death occurred at <u>10:15</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Horace W. Burnton</u> M.D.		22b. DATE SIGNED <u>SEP 29 '60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Burnton, M.D.</u>		22d. ADDRESS <u>10511 Summitt Ave., Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>washington, D. C.</u>		25a. REC'D BY REG STRAR <u>SEP 29 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u>	



10423

10490

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>1 hr.</u>		d. STREET ADDRESS <u>1803 Monroe Street, N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>A.</u> Last <u>Griffith</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1960</u>	
5 SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. Frank T. Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Kate Kenny Beaty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Sister</u> Address <u>As above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 44-3X DUE TO <u>Hypertensive Cardio Vascular</u> H.yo. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2, 1960</u> to <u>Sept 18, 1960</u> that (I) (we) lost saw the deceased alive on <u>Sept 10, 1960</u> and that death occurred at <u>8 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James E. Nolan</u> M.D.		22b. DATE SIGNED <u>9-18-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES E. Nolan</u>		22d. ADDRESS <u>5401 Western Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/20/60</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Friendship, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company- Washington, DC</u> ADDRESS		25a. REC'D BY REGISTRAR <u>SEP 20 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

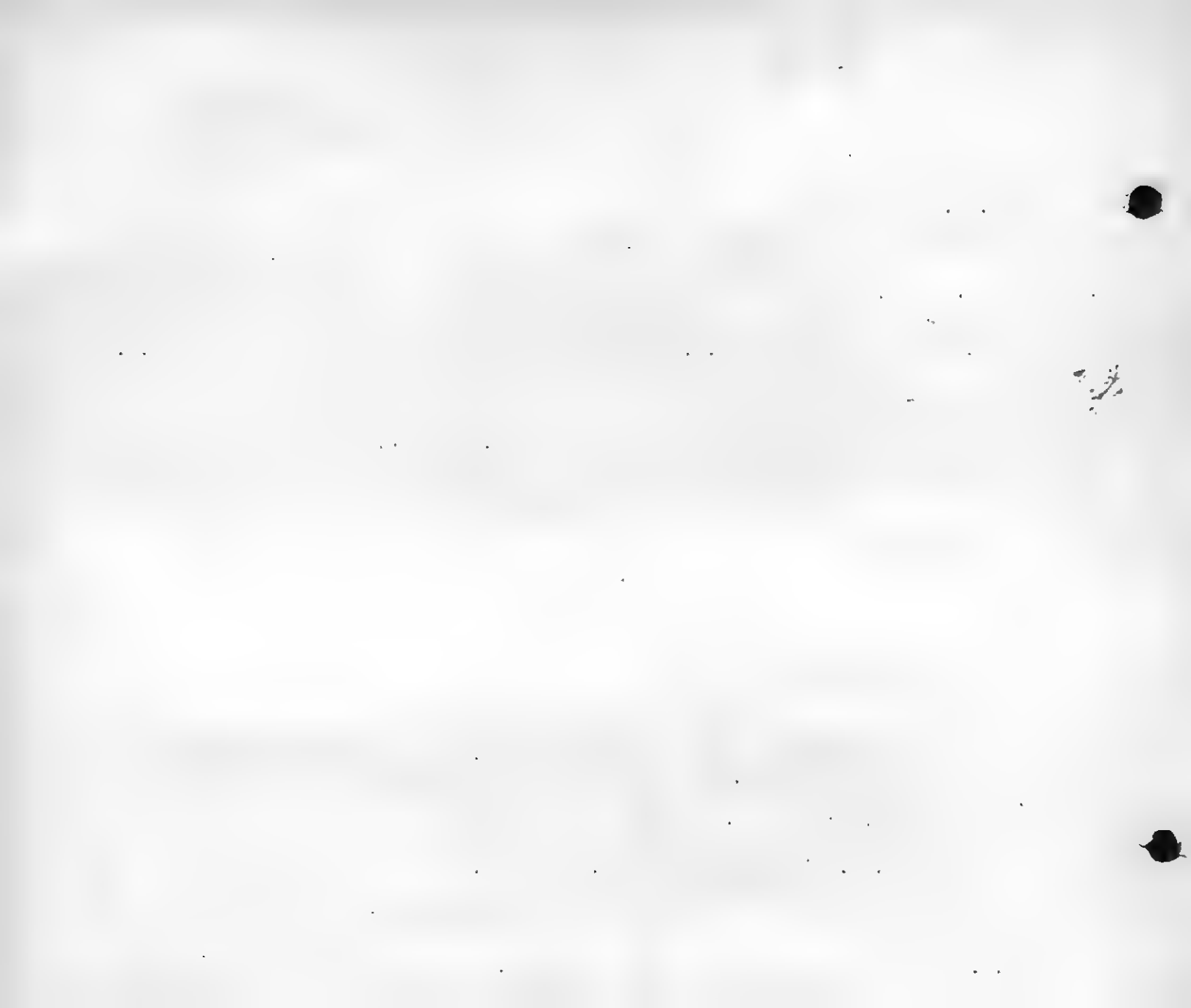
10491

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10430

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural) c LENGTH OF STAY IN 1b 12 days		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 6302 Orchid Drive	
3 NAME OF DECEASED (Type or print) First Middle Last Herbert William HAAS		4. DATE OF DEATH Month Day Year September 20 19 60	
5 SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-23-07
9 AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitary Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S.Public Health	
11 BIRTHPLACE (State or foreign country) Wisconsin		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Edward HAAS		14. MOTHER'S MAIDEN NAME Augusta Louise ABEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO 013-28-9290	
17 INFORMANT (W) Mrs. Helen P. Haas, same as #2 above		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 364X DUE TO Neuritis, Brain stem Acute Schapathic Polymyositis Arteriosclerotic Heart Disease PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 14 days 2+ years		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (his hospital) attended the deceased from Sept. 8 1960 to Sept. 20 1960 , that (I) (we) last saw the deceased alive on Sept. 20 1960 , and that death occurred at 3:45 PM from the causes and on the date stated above			
22a SIGNATURE F. H. O'Connell		22b DATE SIGNED 9-21-60	
22c PHYSICIAN'S NAME (Type) H. F. O'CONNELL, LCDR, MC, USN		22d ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-23-60	23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d LOCATION (City, town, or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		25a REC'D BY REGISTRAR DATE SEP 22 '60	
ADDRESS 7557 Wisc. Ave., Bethesda, Md.		25b REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



10492

CERTIFICATE OF DEATH

10431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b 6 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 1 BROOKE ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIJAH Middle ---- Last HACKETT		4. DATE OF DEATH Month SEPTEMBER Day 7 Year 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-1875
9. AGE (In years last birthday) yrs. 85		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY HACKETT		14. MOTHER'S MAIDEN NAME MARTHA AWKWARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. HOSPITAL RECORDS	
17. ADDRESS OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART FAILURE 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UREMIA DUE TO (c) KIDNEY FAILURE			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from AUGUST 31 , 19 60 , to SEPT. 7 , 19 60 ; that I last saw the deceased alive on SEPT. 7 , 19 60 , and that death occurred at 10:20 M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. I. LEAL M.D.		ADDRESS (Street, city or town, state) GAITHERSBURG, MARYLAND	
DATE SIGNED 9/8/60			
PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/10/60	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surman ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 13 '60	24b. REGISTRAR'S SIGNATURE Orlando S. Fraser

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

10493

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10432

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Pennsylvania b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia, 38		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 6629 North Opal Street			
3. NAME OF DECEASED (Type or print) First William Middle Jay Last Haebel				4. DATE OF DEATH Month September Day 3 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1957		9. AGE (In years lost birthday) 3 yrs	IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	IF UNDER 24 HRS Months 3 Days 3 Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. Haebel				14. MOTHER'S MAIDEN NAME Barbara Shellenberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Necrotizing Granulomata, of unknown Etiology of Lung, Spleen and Lymph Nodes.						INTERVAL BETWEEN ONSET AND DEATH 1 Hour 2 weeks 3 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 29, 1960 to September 3, 1960 , that (I) (we) last saw the deceased alive on September 3, 1960 , and that death occurred 8:55 P.M. from the causes and on the date stated above							
22a. SIGNATURE Philip Fireman M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/4/60	
22c. PHYSICIAN'S NAME (Type) PHILIP FIREMAN, M.D.				The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/60		23c. NAME OF CEMETERY OR CREMATORY Fallside Cemetery		23d. LOCATION (City, town, or county) (State) Borlyn, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Kunkley				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR SEP 7 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

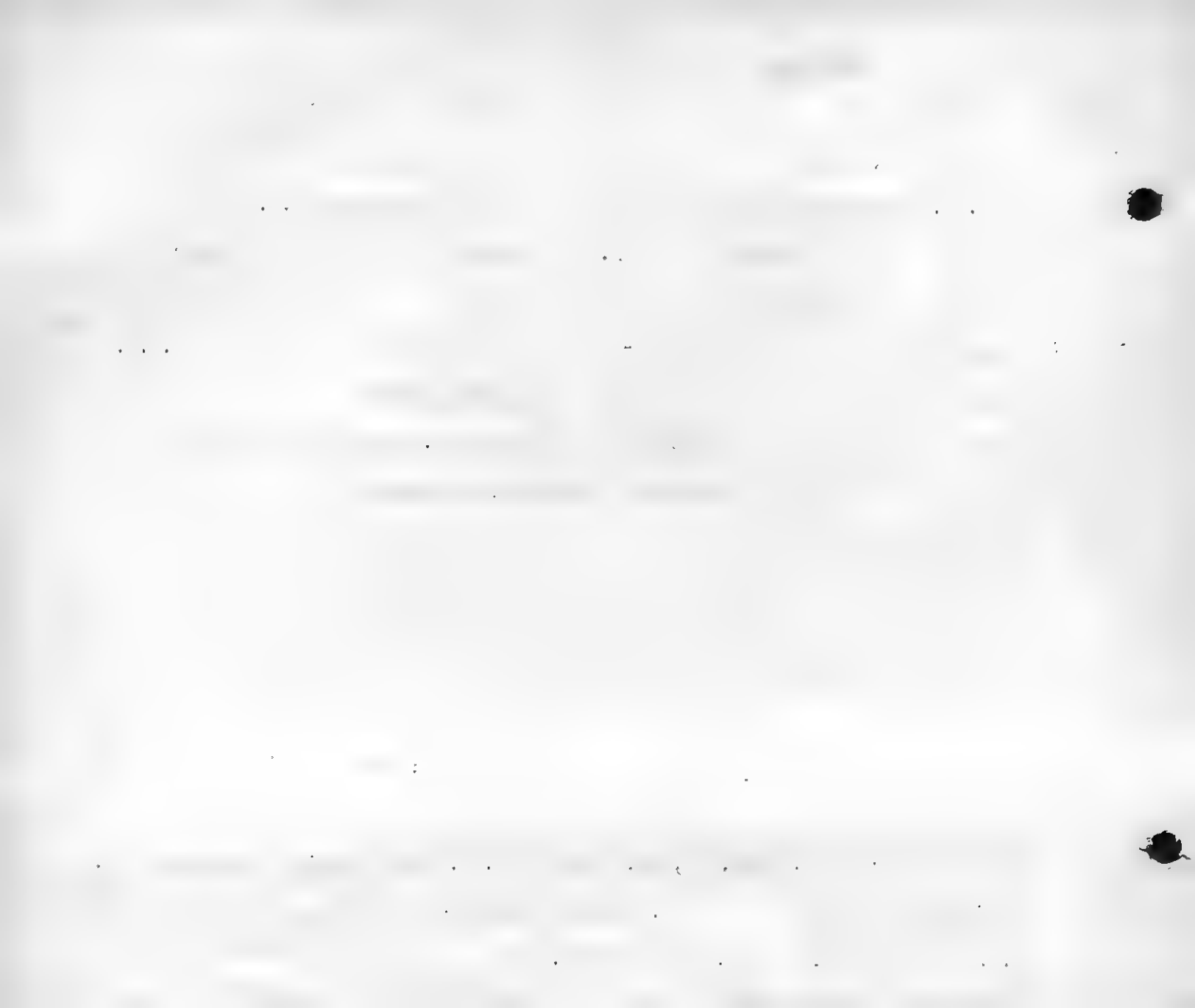


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10494
10433
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 90 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived If institution, Res dence before admission) STATE District of Columbia COUNTY Washington d. STREET ADDRESS 4405 38th Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) First Winifred Middle M, Last HANSEN		4. DATE OF DEATH Month September Day 24 Year 1960				
5 SEX Female	6. COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-8-00	9. AGE (in years last birthday) 59 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Knud Einarson MO			14. MOTHER'S MAIDEN NAME Helen GEORGE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO 547-46-8379		17. INFORMANT Address (H) Harold D. Hansen, same as #2 above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, colon, with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 153-X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that he (this hospital) attended the deceased from June 26 12:03AM to Sept. 24 1960 , that he (we) last saw the deceased alive on Sept. 24 1960 , and that death occurred at 12:03AM , from the causes and on the date stated above.						
22a. SIGNATURE Blair M. Webb M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-24-60		
22c. PHYSICIAN'S NAME (Type) Blair M. WEBB, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, or other disposal cremation		23b. DATE THEREOF 9-26-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS R.A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE SEP 28 1960		25b. REGISTRAR'S SIGNATURE William S. Evans



10434

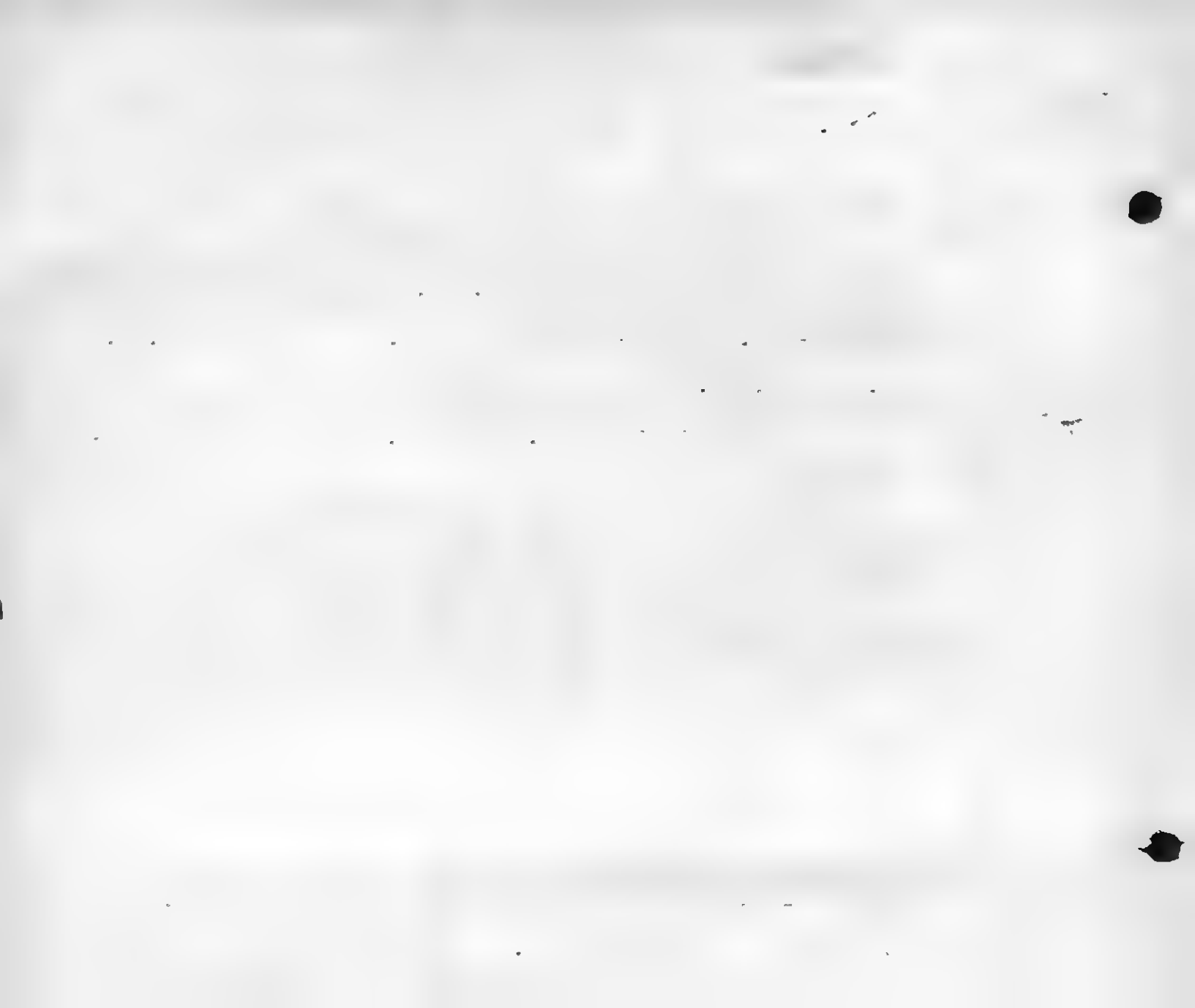
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Nursing Home</u>		d. STREET ADDRESS <u>3501 Husted Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Oscar W. Hanson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Oscar W. Hanson, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Boelker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>716-10-3865</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Same as Item #2.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>153.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatosis</u> (c) <u>Cancer of bowel or liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/9</u> , 19 <u>60</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/23</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave</u> DATE SIGNED <u>9/24/60</u>	
PHYSICIAN'S NAME (Type) <u>John B. Umhau</u>		<u>Cherry Chase 15 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>9-24-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Altoona, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10495

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Etchison		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Etchison	
c. LENGTH OF STAY IN 1b 69 yrs.			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Gaithersburg # 2		d. STREET ADDRESS Gaithersburg Rt. # 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nettie E. Hawkins		4. DATE OF DEATH Month Day Year Sept. 28 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1868
9. AGE (In years birthday) yrs 91		10. IF UNDER 1 YEAR Months Days Hours Min 10 years	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Duvall		14. MOTHER'S MAIDEN NAME Jeresha Penn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -	
17. ADDRESS Mr. J. Ernest Hawkins - Etchison, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 122.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 23, 1960 to September 27, 1960 that I last saw the deceased alive on September 27, 1960 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED Sept. 28, 1960 ACTUAL SIGNATURE James P. Kerr M.D. Damascus, Maryland PHYSICIAN'S NAME (Type) Dr. James P. Kerr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-60	
22c. NAME OF CEMETERY OR CREMATORY Laytonville Meth.		22d. LOCATION (City, town, or county) (State) Laytonville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Barber		24a. REC'D BY REGISTRAR OCT 3 '60	
ADDRESS Laytonville, Md.		24b. REGISTRAR'S SIGNATURE William S. Kinn	

79

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10496

10436

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Cook</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>33 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chicago</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>5025 West Ogden Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Head</u>				4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1934</u>		9. AGE (In years last birthday) <u>26</u> yrs	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>	IF UNDER 24 HRS: Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Architectural</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clarence E. Head</u>				14. MOTHER'S MAIDEN NAME <u>Mary Anna Nail</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>1952-1956 558-40-3569</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia and pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Acute myelocytic leukemia</u> DUE TO (c) <u> </u> </div>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 month</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1, 1960</u> to <u>September 3, 1960</u> , that (I) (we) last saw the deceased alive on <u>September 3, 1960</u> , and that death occurred at <u>8:30aM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Jerome B. Block M.D.</u>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9-4-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jerome B. Block, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/8/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10437

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park, Maryland</u> c. LENGTH OF STAY IN TB <u>14 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>S.S. Maryland</u> Phone: <u>Pa 9700 X7464</u> d. STREET ADDRESS <u>10600 Lorain Ave. S.S., Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>John</u> Last <u>Herczog</u>		4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/4/20</u>
9. AGE (in years last birthday) <u>40</u> yrs IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Admin - Dept of Defense</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Mov't. U.S.</u> 11. BIRTHPLACE (State or foreign country) <u>Ohio - USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Herczog</u>		14. MOTHER'S MAIDEN NAME <u>Julia Beda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes, WW2 Army</u>		16. SOCIAL SECURITY NO <u>295-03-9072</u>	
17. INFORMANT <u>Wife</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> DUE TO <u>587.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a.m. <u> </u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from August 22, 1960 to Sept 4, 1960 that (I) (we) last saw the deceased alive on Sept 4, 1960 and that death occurred at 5 PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Lysle Williams</u> M.D.		22b. DATE SIGNED <u>Sept 5, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lysle Williams</u>		22d. ADDRESS <u>8700 Coleville Rd, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/8/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. J. J. J. J.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>		25c. REGISTRAR'S NAME <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10438

10497

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 311 Farragut St., N.W.	
3 NAME OF DECEASED (Type or print) First Jacquelyn Middle Yvette Last HILL		4. DATE OF DEATH Month September Day 26 Year 19 60	
5 SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-49
9 AGE (In years lost birthday) 10 yrs		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11 BIRTHPLACE (State or foreign country) Florida		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. HILL		14. MOTHER'S MAIDEN NAME Eva SAPP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. None	
17 INFORMANT (M) Mrs. Eva Hill, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma multiforme DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) person attended the deceased from <u>Sept. 9</u> 19 <u>60</u>, to <u>Sept. 26</u> 19 <u>60</u>, that (I) see last saw the deceased alive on <u>Sept. 26</u> 19 <u>60</u>, and that death occurred on <u>Sept. 26</u> 19 <u>60</u> at <u>2:40AM</u> from the causes and on the date stated above			
22a SIGNATURE W. H. Druckemiller		22b DATE SIGNED 9-26-60	
22c PHYSICIAN'S NAME (Type) W. H. DRUCKEMILLER, CAPT, MC, USN		22d ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10/3/1960	
23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City, town, or county) (State) Arlington Virginia	
24 FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis, 1432 "U" St., NW, Washington, DC		25a REC'D BY REGISTRAR DATE SEP 28 '60	
25b REGISTRAR'S SIGNATURE Arthur S. Fraw			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10439

10498

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS Route #2			
3. NAME OF DECEASED (Type or print) First Walter Middle Miller Last Hill				4. DATE OF DEATH Month Sept. Day 14 Year 19 60			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/11		9 AGE lost 48 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY Cave Ford		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Hill				14. MOTHER'S MAIDEN NAME Bertie Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 212-63-8245		17 INFORMANT Mother, Mrs. Bertie Hill LePron		Address Baltimore Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute posterior myocardial infarction DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 days DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 8 hrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Sept. 11, 1960 to Sept. 14, 1960 , that (I) (we) lost the deceased alive on Sept. 14, 1960 , and that death occurred at 5 PM , from the causes and on the date stated above.							
22a. SIGNATURE Robert N. Coale				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED Sept. 14, 1960	
22c PHYSICIAN'S NAME (Type) ROBERT N. COALE				22d ADDRESS 4630 Montgomery Ave, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Sept. 17, 1960		23c NAME OF CEMETERY OR CREMATORY Laytonsville Meth.		23d LOCATION (City, town, or county) (State) Laytonsville, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Francis K. Barber				ADDRESS Laytonsville, Md.		25a REC'D BY REGISTRAR SEP 19 '60	
				25b REGISTRAR'S SIGNATURE Arthur L. Hand			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

10499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 1 Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 1177-3	
c. LENGTH OF STAY IN 1b <u>30 days</u>		d. STREET ADDRESS <u>1102-10th St. S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Everest Care Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN FRANCIS HOFFMAN</u>		4. DATE OF DEATH Month Day Year <u>9 - 19 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-11-07</u>
9. AGE (In years last birthday) yrs. <u>53</u>		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Reggie County Club</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Annie A. Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>Yes 3-2-43, 11-13-45</u>		16. SOCIAL SECURITY NO. <u>575-30-7369</u>	
17. INFORMANT <u>George H. Hoffman</u>		Address <u>1102-10th St. S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus & metastasis</u> DUE TO <u>152X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> _____	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from <u>Sept 18</u> , 19 <u>60</u> , to <u>Sept 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 18</u> , 19 <u>60</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Samuel Levy, M.D.</u> 9/19/60 PHYSICIAN'S NAME (Type) <u>DERMENT A. BONIFANT, Sandy Spring, Md.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-22-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belington Mth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Belington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber E. Inc.</u>		ADDRESS <u>517-11th St. S.E.</u>	
24a. REC'D BY REGISTRAR <u>SEP 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10500

Item 9

CERTIFICATE OF DEATH

10441

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring (Rural)				d. STREET ADDRESS Box 13			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Bradford Burnside Hopkins				4. DATE OF DEATH Month Day Year Sept. 22 19 60			
5 SEX M		6 COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH 12/26/07	
9 AGE (in years last birthday) 52 43 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Manual Labor		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Francis Hopkins				14. MOTHER'S MAIDEN NAME Annie Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) Unknown.		17 INFORMANT Address Dora Hopkins Sandy Spring, Md. Box 13			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral edema DUE TO 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right lateral ventricular hemorrhage DUE TO 2 days (c) Hypertensive Cardiovascular Renal disease Years				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Sept. 21, 1960 to Sept. 21, 1960 that (I) (we) last saw the deceased alive on Sept. 21, 1960 , and that death occurred at Sept. 21, 1960 M, from the causes and on the date stated above.							
22a. SIGNATURE G. Bowditch Hunter, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 22, 1960	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF 9-24-60		23c. NAME OF CEMETERY OR CREMATORY Sandy Spring		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Robert J. Schander ADDRESS Rockville, Md.				25a. REC'D BY REGISTRAR SEP 26 '60		25b. REGISTRAR'S SIGNATURE William J. Hunter	

2

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10420

CERTIFICATE OF DEATH

10442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>23</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>113 Brydton Court</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vanessa Lynn Huebner</u>		4. DATE OF DEATH Month Day Year <u>5-11</u> <u>2</u> <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 48 PM</u> <u>Sept. 11, 1960</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <u>22</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Adrian J. Huebner</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> DUE TO <u>accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 11, 1960</u> to <u>Sept 12, 1960</u> , that I last saw the deceased alive on <u>Sept 12, 1960</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hyman Colvin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1211 Sheridan Street Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Hyman Colvin</u>		<u>1211 Sheridan St., N.W. Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-12-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D.</u>		ADDRESS <u>Washington Sanitarium and Hospital, Takoma Park, Maryland</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

SEP 14 1960

CERTIFICATE OF DEATH

Reg. Dist. No.

10443

10455

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13005 PARKLAND DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Jr. Last Hughes		4. DATE OF DEATH Month 9 Day 14 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-23
9. AGE (In years last birthday) 37 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS M. HUGHES		14. MOTHER'S MAIDEN NAME LUCY A. THOMAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. THOMAS M. HUGHES (Same as 2d)	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal Hemorrhage 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Wernia DUE TO (c) Chronic glomerulonephritis		INTERVAL BETWEEN ONSET AND DEATH 30 min. 1 yr. 22 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1, 1953 to 9/14/1960 that I last saw the deceased alive on 7/14/1960 , and that death occurred at 6:50 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Rockville, Md.		DATE SIGNED 9/14/60	
ACTUAL SIGNATURE Stephen N. Jones		M.D. Rockville, Md.	
PHYSICIAN'S NAME (Type) STEPHEN N. JONES		L. D. ROCKVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-16-60	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS WASH. D.C.	
24a. REC'D BY REGISTRAR SEP 16 '60		24b. REGISTRAR'S SIGNATURE Charles J. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10501

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10444

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lay Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 14300 Lay Hill Rd.	
3. NAME OF DECEASED (Type or print) Norman Lawrence HULL		4. DATE OF DEATH Sept. 21 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret.) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Hull		14. MOTHER'S MAIDEN NAME Sarah Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Preston Hull		Address 1500 Atwood Rd SS Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary heart disease (c) diabetes & cirrhosis liver		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes & cirrhosis liver			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1/55 19 to 9/21/60 19 that (I) (we) last saw the deceased alive on 9/20 19 60 and that death occurred at 645M from the causes and on the date stated above.			
22a. SIGNATURE Patrick C. Jameson M.D.		22b. DATE 9/21/60	
22c. PHYSICIAN'S NAME (Type) PATRICK C. JAMESON		22d. ADDRESS 12020 Heavens Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/23/60	
23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. P. Pumphrey, Inc.		25a. REC'D BY REGISTRAR SEP 26 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kiser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10448

10446

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>		d. STREET ADDRESS <u>4012 Virgilila Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Jannie</u> Middle <u>May</u> Last <u>Jacobs</u>		4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1870</u>
9. AGE (In years last birthday) <u>90</u> yrs		10. UNDER 1 YEAR Months Days Hours Min	11. UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henny Chase</u>		14. MOTHER'S MAIDEN NAME <u>Ella Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT Address <u>Mrs. F.W. Stover 7616 Conn. Ave. N.W. Ch. 4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>82.4</u> DUE TO (b) <u>Acute Respiratory xxx Failure</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hyperpyrexia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>48 hrs.</u> <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sep 2</u> <u>1960</u> to <u>Sep 9</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>Sep 6</u> <u>1960</u> , and that death occurred at <u>7:00p</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u> M.D.		22b. DATE <u>September 9, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u>		22d. ADDRESS <u>10609 Concord St., Kensington, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/12/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 14 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Howard</u>	

مكة المكرمة - ١٤٤٢ هـ

١٤



is necessary,
director. Page
for your files
ate Board of Health
h.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person has been arrested or detained, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home; give Page 4 to the State Medical Examiner's Office along with Form PM-100. The State Medical Examiner's Office may retain the certificate if it is needed for legal purposes.

TO FUNERAL DIRECTOR: Pages 1 through 4 should be used for burial-transit permit. Fill pages 1 and 2 with the State Medical Examiner's Office information. Pages 3 and 4 are for the funeral home. Complete page 3 if the body is to be buried, cremated, or removed, and in any event within 72 hours after death. If the body is to be stored in a vault, complete page 3 if the body is to be stored in a vault, and in any event prior to burial, cremation, or removal, and in any event within 72 hours after death. If the body is to be stored in a vault, complete page 3 if the body is to be stored in a vault, and in any event within 72 hours after death.

V5. A15ME
5M 7/59

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4807 Dorset Ave</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u></p> <p>d. STREET ADDRESS <u>4807 Dorset Ave</u></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Beela</u></p> <p>5. SEX <u>Female</u></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p> <p>13. FATHER'S NAME <u>Abraham Laddon</u></p>		<p>c. LENGTH OF STAY IN MD <u>43 yrs</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1960</u></p> <p>6. COLOR OR RACE <u>White</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>8-24-1879</u></p> <p>9. AGE (In years last birthday) <u>81</u> yrs.</p> <p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p>11. BIRTHPLACE (State or foreign country) <u>Prussia</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p> <p>14. MOTHER'S MAIDEN NAME <u>Bertha</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u></p> <p>16. SOCIAL SECURITY NO. <u>—</u></p> <p>17. INFORMANT <u>Victor Jaffe</u></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of furon heart disease</u></p> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.</p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.</p> <p>EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u></p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DATE SIGNED <u>9-4-60</u></p> <p>Address (Street, city, town, or county)</p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>22b. DATE THEREOF <u>9-7-60</u></p> <p>22c. NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew Cong. Cem.</u></p>		<p>22d. LOCATION (City, town, or country) (State) <u>Washington - D.C.</u></p> <p>24a. REC'D BY REGISTRAR DATE <u>SEP 8 '60</u></p> <p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u></p>	
<p>23. FUNERAL DIRECTOR <u>B. Danzansky</u></p> <p>ADDRESS <u>1505-3501-14th St. N.W.</u></p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10448

10503

Item 1c Film 6271-9-23-60 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 50 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pelzer	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 11 Green Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Herbert Middle William Last Janssen			4. DATE OF DEATH Month September Day 19 Year 1960		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH January 13, 1930		9. AGE (In years lost birthday) 30 yrs		IF UNDER 1 YEAR Months 30 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) T/Sgt. U.S. Air Force		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Carl Janssen			14. MOTHER'S MAIDEN NAME Tillie Kuper		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, pulmonary edema 200.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant lymphoma, widely disseminated to lymph nodes, abdominal thoracic viscera and skin DUE TO (c) months					INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyperparathyroidism					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from July 26, 1960 to September 19, 1960 that (I) (we) last saw the deceased alive on September 19, 1960 , and that death occurred at 5:50 PM from the causes and on the date stated above.					
22a. SIGNATURE Jerome B. Block		M.D. Jerome B. Block, M.D.		22b. DATE SIGNED September 20, 1960	
22c. PHYSICIAN'S NAME (Type) Jerome B. Block, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF SEPT. 23 1960		23c. NAME OF CEMETERY OR CREMATORY PELZER So. Carolina	
23d. LOCATION (City, town, or county) Pelzer So. Carolina		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Ruthie Turner		ADDRESS 816 N. St. N.E., R. 2		25a. REC'D BY REGISTRAR DATE SEP 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10449

10421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>" "</u> <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7121 Willow Avenue</u>				d. STREET ADDRESS <u>7121 Willow Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>P.</u> Last <u>JESTER</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1879</u>	9. AGE (In years last birthday) <u>80 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hearing Aid Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hearing Aid</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Jester</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. B. Judd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-03-7406</u>		17. INFORMANT <u>Mrs. Marian S. Jester</u> Address <u>(Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 4 - DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <u>Severe Arteriosclerosis Generalized</u> (c) <u>5-6 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Arteriosclerosis Generalized of long yrs.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1956</u> , to <u>19 Sept. 1960</u> , that I last saw the deceased alive on <u>19 Sept. 1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>J. B. LEEFER</u>				DATE SIGNED <u>19 Sept 1960</u>			
PHYSICIAN'S NAME (Type) <u>J. B. LEEFER M.D.</u>				ADDRESS (Street, city or town, state) <u>7121 Willow Ave. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>	

10422

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

10450

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If instit on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>		d. STREET ADDRESS <u>7301 23rd Ave Lewisdale</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marshall Dewey Johns</u>		4. DATE OF DEATH Month Day Year <u>9 22 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-99</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Charles Johns</u>		14. MOTHER'S MAIDEN NAME <u>Ione Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Takoma Park Md</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute hemorrhagic, aneurysm</u> DUE TO <u>587.0</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 17</u> 19 <u>60</u> , to <u>Sept 22</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Sept 22</u> 19 <u>60</u> , and that death occurred at <u>4:20</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>H. W. Payne</u> M.D.		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>HEUNGNE O LUK FIELD MD</u>		22d. ADDRESS <u>6826 Piggys Rd Hyattsville Md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u></u>		23b. DATE THEREOF <u>9-26-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ch. Nat Cem</u>		23d. LOCATION (City, town or county) (State) <u>Cal</u> <u>Pa</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 26 '60</u>	
ADDRESS <u>300-4th St. N.E. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10451

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Little Falls - Potomac River		e. STREET ADDRESS 1310 N. Courthouse Road	
3. NAME OF DECEASED (Type or print) First IRELAND Middle JOHNSON Last JOHNSON		4. DATE OF DEATH Month Sept Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Jan 1928
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR: Months 32 Days 32 Hours 32 Min. 32	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sgt. - US Army		11b. KIND OF BUSINESS OR INDUSTRY Soldier	
12. BIRTHPLACE (State or foreign country) West Virginia		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME Clyde Johnson		15. MOTHER'S MAIDEN NAME Mina Harvey	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		17. SOCIAL SECURITY NO. active duty 234-42-3365	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 850X DUE TO Condition, if any, which gave rise to immediate cause (b) Drowning (c), stating the underlying cause last. (c) _____ DUE TO _____		19. INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Boat over turned going over falls	
20c. TIME OF INJURY Hour 7:00 Minute 00 Month 9/18 Year 19 60		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River	
20e. (City or town) Brookmont, Montgomery, Md.		20f. (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion a death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) SEPT. 23 1960 Burial		22b. DATE THEREOF SEPT. 23 1960	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME 86 HST. NE DC 2		24a. REC'D BY REG-STRAR DATE SEP 23 '60	
24b. REGISTRAR'S SIGNATURE Caroline P. H.		DATE SIGNED 9/20/60	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10452

10505

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write FLRA, and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 19 Days		d. STREET ADDRESS 3700 Mass Ave, NW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILDRED Middle TABB Last JOHNSON		4. DATE OF DEATH Month September Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-05
9. AGE (In years lost b r h day) 55 yrs		IF UNDER 1 YEAR Months Days Hours Mm.	IF UNDER 24 HRS Months Days Hours Mm.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warner Lewis Tabb		14. MOTHER'S MAIDEN NAME Minnie Weedon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Richard F.J. Johnson Jr.		Address Washington DC 3700 Mass Ave NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-16 1960 , to 9-4 1960 , that (I) (we) last saw the deceased alive on 9-4 1960 , and that death occurred at 6:40 AM from the causes and on the date stated above.			
22a. SIGNATURE L.J. HINES, CDR MC USN		22b. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
22c. PHYSICIAN'S NAME L.J. HINES, CDR MC USN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-8-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Grawler & Sons		25a. REC'D BY REGISTRAR DATE SEP 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

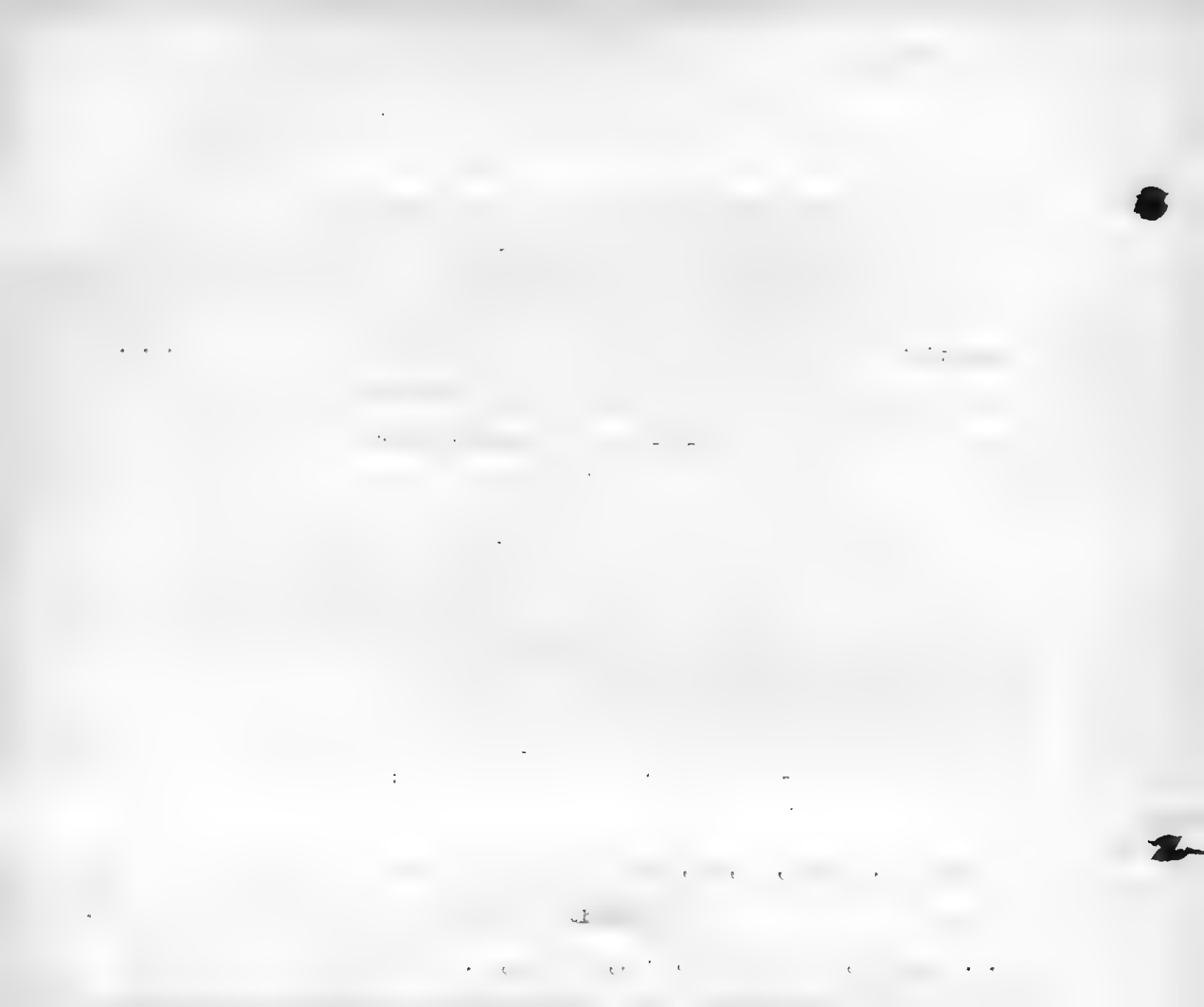
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10453

10506

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md</u>				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <input checked="" type="checkbox"/> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lancaster</u> d. STREET ADDRESS <u>48 S. Water Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Janie</u> Middle <u>Marie</u> Last <u>JUMBELICK</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>9</u> Year <u>1960</u>			
5 SEX <u>Female</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-12-34</u> 9. AGE (In years last birthday) <u>26</u> yrs		IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
13. FATHER'S NAME <u>Rosser CALVIN</u>				14. MOTHER'S MAIDEN NAME <u>Bazzle TRACY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>228-38-3273</u>		17. INFORMANT <u>Hospital records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Initial Stenosis and Insufficiency</u> DUE TO (c) <u>Rheumatic valvulitis</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-1-</u> <u>1960</u> to <u>9-9-</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>9-9-</u> <u>1960</u> , and that death occurred at <u>10:08 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Robert C. Thomas</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>9-10-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert C. THOMAS, LT, MC, USN</u>				22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL CREMATION <u>Burial</u>		23b. DATE THEREOF <u>9-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Transit</u>			
23d. LOCATION (City, town, or county) <u>Lancaster County, Penna.</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>13 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Robert C. Thomas</u>				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2. Film 62/3 10-20-60 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland D.C. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 15½ days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Washington	
3. NAME OF DECEASED (Type or print) Bertha Younger Keller		d. STREET ADDRESS 5425 Conn. Ave. N.W. Ledeau Gardens Nursing Home	
4. DATE OF DEATH Month 9 Day 6 Year 1960		5. IS RES. DECL. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/1885
9. AGE (in years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 7 Days 5	
11. IF UNDER 24 HRS Hours 13 Min. 00		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired PBX Operator Telephone		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Younger		14. MOTHER'S MAIDEN NAME Virginia Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-44-8125	
17. INFORMANT Mrs. Marjorie G. Matthews, 11,905 Dalewood Dr. Silver Spring, Md.		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2nd & 3rd degree burns involving neck, chest & arms DUE TO (c) 15½ days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Clothes caught afire while lighting cigarette with lighter	
20c. TIME OF INJURY Month, Day, Year 8/21/60 Hour 5:30 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home		20f. (City or town) (County) (State) Kensington Montg Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 9/6/60	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/9/60	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 9/13/60		24b. REGISTRAR'S SIGNATURE C. L. S. HARRIS	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 15M 9/59

10508

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10456

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3403 University Boulevard, Apt. F6			
3 NAME OF DECEASED (Type or print) First Harris Middle Jackson Last Kirkland, Jr.				4. DATE OF DEATH Month September Day 10 Year 19 60			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 15, 1955	9. AGE (In years lost birthday) 5 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Harris J. Kirkland, Sr.				14 MOTHER'S MAIDEN NAME Edna M. Temples			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding diathesis DUE TO (b) Thrombocytopenia DUE TO (c) Acute lymphocytic leukemia INTERVAL BETWEEN ONSET AND DEATH 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (♣) (this hospital) attended the deceased from January 15, 19 60 to September 10, 19 60 that (♣) (we) last saw the deceased alive on September 10, 19 60 , and that death occurred on September 10, 19 60 from the causes and on the date stated above.							
22a. SIGNATURE Haskins K. Kashima M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/11/60	
22c. PHYSICIAN'S NAME (Type) Haskins K. Kashima, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, or other disposal (State) SHIP RR.		23b. DATE THEREOF 9-12-60		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) MULBERRY, FLA.	
24. FUNERAL DIRECTOR'S SIGNATURE CHAMBERS FUNERAL HOME				ADDRESS 1400 CAPLAN ST. WASH, D.C.		25a. REC'D BY REGISTRAR SEP 19 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10457

10402

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 SILVER SPRING			
c. LENGTH OF STAY IN 1b 8 MONTHS				d. STREET ADDRESS 12805 PARKER AVENUE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2805 PARKER AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH KURTZ				4. DATE OF DEATH Month Day Year SEPT. 17 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 13, 1916	
9. AGE (in years last birthday) 44 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - Own Home				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DAVID HUMBERSON				14. MOTHER'S MAIDEN NAME LONA FRIEND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 218-20-1736		17. INFORMANT Address ANDREW A. KURTZ (HUSBAND) SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION							
416X DUE TO (b) RHEUMATIC HEART DISEASE							
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) NONE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) NONE							
20c. TIME OF INJURY Month Day Year Hour o m p m 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JUNE 1960 to SEPT. 17, 1960 that (I) (we) last saw the deceased alive on AUG. 24, 1960 and that death occurred at 3 AM , from the causes and on the date stated above.							
22a. SIGNATURE Belden R. Reap				22b. DATE SIGNED 9/17/60			
22c. PHYSICIAN'S NAME (Type) BELDEN R. REAP				22d. ADDRESS 11502 GRANDVIEW AVE, WHEATON MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 1960		23c. NAME OF CEMETERY OR CREMATORY Bloomingsrose Methodist Church Cem., Friendsville, Garrett, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Raymond A. Ziska				25a. REC'D BY REGISTRAR DATE SEP 21 '60		25b. REGISTRAR'S SIGNATURE William S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Montana b. COUNTY Cascade	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Falls 6242	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 2722 North 6th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Melvin Robert Lager		4. DATE OF DEATH Month Day Year September 21, 1960	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1924
9 AGE (In years last birthday) 35 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	
10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Montana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Carl A. Lager		14. MOTHER'S MAIDEN NAME Inga A. Larsen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 516-22-1088	
INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO 154.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration in aorta (c) Patent ductus arteriosus Congenital INTERVAL BETWEEN ONSET AND DEATH approximately 1 hour 2 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 13, 1960 to September 21, 1960 that I last saw the deceased alive on September 21, 1960 and that death occurred at 1:46 P.M. ADDRESS (Street, city or town, state) DATE SIGNED Roland Folse M.D. The Clinical Center, National 9/22/60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Roland Folse, M.D. Institutes of Health, Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	22b. DATE THEREOF 9-22-60	22c. NAME OF CEMETERY OR CREMATORY Hill County Cemetery	22d. LOCATION (City, town or county) (State) Hill County, Montana
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DATE SEP 23 '60	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Little Falls - Potomac River		d. STREET ADDRESS 226 "I" Street, N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Lee Last LAMBERT		4. DATE OF DEATH Month September Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1941
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 7 Days 9	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Recapper		10b. KIND OF BUSINESS OR INDUSTRY Tire Recapping	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jessie Lambert		14. MOTHER'S MAIDEN NAME Christine Stratton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 234-60-9425	
17. INFORMANT Montg. Co. Police Records-Bethesda Station		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Boat overturned going over falls		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 7:00 9/18 19 60 Hour PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River		20f. (City or town) (County) (State) Brookmont Montgomery Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED September 21, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/24/60	
22c. NAME OF CEMETERY OR CREMATORY Lambert Cemetery		22d. LOCATION (City, town, or county) (State) Fry, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 23 '60	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

10511

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jersey City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 208 South Street	
3. NAME OF DECEASED (Type or print) First Middle Last Carole Ann Lane		4. DATE OF DEATH Month Day Year September 20 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1936
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min 10 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Calnan		14. MOTHER'S MAIDEN NAME Vera Giovannetti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrhythmia and arrest 41X DUE TO Rheumatic Heart disease with mitral stenosis and insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 hours years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 5, 19 60 , to September 20, 19 60 , that I last saw the deceased alive on September 20, 19 60 , and that death occurred at 12:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James L. Talbert		DATE SIGNED 9/20/60	
PHYSICIAN'S NAME (Type) James L. Talbert, M.D.		M.D. The Clinical Center, National	
Institutes of Health, Bethesda 14, Maryland			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Bur-transit	9/21/60	Flower Hill Cemetery	Bergen New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE SEP 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10461

10512

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. STREET ADDRESS 434 Quade Street 161			
3. NAME OF DECEASED (Type or print) First Robert Middle Manuel Last LANHAM				4. DATE OF DEATH Month September Day 22 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-29-20	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Rufus L. LANHAM				14. MOTHER'S MAIDEN NAME Dettie E. MANUEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) 1939 to 1958				16. SOCIAL SECURITY NO 400-18-8222			
17. INFORMANT (W) Mrs. Marion R. Lanham, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, bile duct c DUE TO (b) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 6 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour o m p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from Sept. 8 , 19 60 , to Sept. 22 , 19 60 , that (I) physician saw the deceased alive on Sept. 22 , 19 60 , and that death occurred at 9:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE W. D. Hooper				22b. DATE SIGNED 9-22-60			
22c. PHYSICIAN'S NAME (Type) W. D. HOOPER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros., 1661 Good Hope Rd, SE, WashDC				25a. REC'D BY REGISTRAR SEP 26 '60		25b. REGISTRAR'S SIGNATURE Charles S. James	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10513

10462

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 40 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
OR INSTITUTION		d. STREET ADDRESS 805 Chalfonte Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle Edwin Last LATIMER		4. DATE OF DEATH Month September Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-02
9. AGE (In years last birthday) yrs 58		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Clarence E. LATIMER		14. MOTHER'S MAIDEN NAME Elisabeth SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1924 to 1953	
17. INFORMANT Mary K. LATIMER		Address 805 Chalfonte Dr., Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tumor, carcinoma, metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lung DUE TO (c) Coronary artery, primary		INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-7-60 to 9-16 , that (I) (we) last saw the deceased alive on 9-16 19 60 , and that death occurred at 4:50 PM from the causes and on the date stated above.			
22a. SIGNATURE F. H. O'CONNELL		22b. DATE SIGNED 9/17/60	
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, USN		22d. ADDRESS U. S. NAVAL HOSPITAL, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-20-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawlers's & Sons		25a. REC'D BY REGISTRAR SEP 20 '60	
25b. REGISTRAR'S SIGNATURE William J. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10514

CERTIFICATE OF DEATH

10463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORBETH</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST. PHILomena's Rest Home</u>				d. STREET ADDRESS <u>1621 Irving St NW.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna T Leddy</u>				4. DATE OF DEATH Month Day Year <u>9 25 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 19, 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P. Leddy</u>				14. MOTHER'S MAIDEN NAME <u>HELEN HEALY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNAVAILABLE</u>		17. INFORMANT Address <u>MRS ACATHA JONES 112 2nd ST N.E.W.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>20 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 5</u> , 19 <u>60</u> , to <u>Sept 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>60</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Harry J. Kicheter</u> M.D. <u>5527 Surrey St.</u>				<u>9/25/60</u>			
PHYSICIAN'S NAME (Type) <u>H. J. Kicheter</u>				<u>Cherry Chase, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm T. Atterwell</u>				ADDRESS <u>3603 14th St NW</u>		24a. REG'D BY REGISTRAR DATE <u>SEP 27 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith B. Kinnard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10464

10449

1 PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>421 Buchanan St. NW Wash DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>		d. STREET ADDRESS <u>3000 McComas Ave. NW</u>	
3 NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>E.</u> Last <u>Lewis</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1960</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1886</u>
9 AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Chas. E. Winstead</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Dungan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Wilbert C. Lewis 509 Somerset Pl. Chillum</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Melanoma</u> <u>1957</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:05</u> p.m. <u>9</u> <u>2</u> <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>MAY 7</u> 19 <u>60</u> to <u>SEPT 2</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>NOV 27</u> 19 <u>60</u> , and that death occurred at <u>5⁰⁰</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Arthur S. Kline</u> M.D.		22b. DATE SIGNED <u>Sept 2, 1960</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>5011 Columbia Rd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>9-6-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dick Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
ADDRESS <u>4812 Ga Ave NW</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10423

VR A15 (4)
ISM 9/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

M

051

I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8, 9, 11 Film 6-11 9-23-60

10515

10466

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 110 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 149 Ritchie Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude XXXXX		4. DATE OF DEATH Month Day Year September 20 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-77 1877
9. AGE (in years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Wisconsin/ Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Wilson		14. MOTHER'S MAIDEN NAME Emma Thatcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. (S) Gerald F. Young, 7611 Eastern Ave., SS, Md.	
17. INFORMANT (S) Gerald F. Young, 7611 Eastern Ave., SS, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Inanition DUE TO (c) Complete paralysis from multiple cerebral vascular accidents		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 2 1960 to Sept. 20 1960 that (I) (we) lost saw the deceased alive on Sept. 20 1960 , and that death occurred at 8:30AM M, from the causes and on the date stated above.			
22a. SIGNATURE R. G. Muth M.D.		22b. DATE SIGNED 9-20-60	
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-24-60	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. E. Pumphrey, 8434 Georgia Ave., Silver Spring, Md.		25a. REC'D BY REGISTRAR SEP 22 60	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

Pass. Warner & Pumphrey the for W & S Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. M

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10467

10403

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b Do A
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shumanville & Jean Richard Rd

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland
d. STREET ADDRESS Mink Hollow Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Samuel Carlton McCann
4. DATE OF DEATH Sept 27 1960
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 5-22-40
9. AGE (In years last birthday) 20 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lat. Technician 10b. KIND OF BUSINESS OR INDUSTRY chemical co. 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Samuel Adams Mc Fann 14. MOTHER'S MAIDEN NAME Barbara Lee Keener

15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16. SOCIAL SECURITY NO. Robert Lee Mc Fann - Brother 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration
822 multiple DUE TO multiple
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) compound fracture of skull
DUE TO (c) sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Brain trauma involved in accident

20c. TIME OF INJURY Month, Day, Year 10/10 p.m. 9-27 1960 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) Silver Spring monty md (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 9-28-60
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Broschart M.D. EXAMINER'S NAME (Type) FRANK J. Broschart
Address (Street, city, town, or county) Clarksville Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10/1/60 22c. NAME OF CEMETERY OR CREMATORY St. Louis Cem. 22d. LOCATION (City, town, or country) (State) Clarksville Md

23. FUNERAL DIRECTOR L E Witt Donaldson ADDRESS Louis Md 24a. REC'D BY REGISTRAR OCT 5 '60 24b. REGISTRAR'S SIGNATURE Carlton S. Kraus

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE MARYLAND b COUNTY MONTGOMERY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle CLIFTON Last MAGRUDER		4. DATE OF DEATH Month SEPT. Day 2 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/20/05
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto mechanic		10b. KIND OF BUSINESS OR INDUSTRY Cave Ford Co.	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WALTER T. MAGRUDER	
14. MOTHER'S MAIDEN NAME CORRIE CASE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO 577-10-1734		17. INFORMANT Address Mrs. Evelyn V. Magruder, 10,818 Newport Mill Rd., Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/21, 1960 to 9/2, 1960 that I last saw the deceased alive on 9/1, 1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave, Silver Spg, Md. DATE SIGNED 9/2/60 ACTUAL SIGNATURE Donald Nelson M.D. PHYSICIAN'S NAME (Type) DONALD NELSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/6/60	22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond D. Jarka		24a. REC'D BY REGISTRAR DATE SEP 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10404

CERTIFICATE OF DEATH

10469

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE 3823 MASS AVE N.W. b COUNTY WASH DC.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING MARYLAND c LENGTH OF STAY IN 1b 2 YRS 5 MO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC.	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME		d. STREET ADDRESS 3823 MASS AVE NW	
3. NAME OF DECEASED (Type or print) First Middle Last Anna B Maloney		4. DATE OF DEATH Month Day Year September 17 1960	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1891
9. AGE (in years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ROSENBERG		14. MOTHER'S MAIDEN NAME SARAH FISHMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN	
INFORMANT Address Lester Rosenberg - 3823 - Mass Av. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 3-1-X DUE TO Cerebral Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 max years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1958 to September 17, 1960 that I last saw the deceased alive on September 16, 1960 , and that death occurred at 10:00 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Boris Rabkin M.D. 1019 University Boulevard East 9/17/60 Silver Spring, Maryland			
22a. BURIAL, CREMATION, REINBURSEMENT (Type) BURIAL			
22b. DATE THEREOF SEPT. 20, 1960		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY	
22d. LOCATION (City, town, or county) (State) ARLINGTON VA.		24a. REC'D BY REGISTRAR DATE SEP 21 '60	
23. FUNERAL DIRECTOR'S SIGNATURE D. Langenberg		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10470

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cherry Chase

c. LENGTH OF STAY IN TB

3 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

4614 Harrison st

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

md

b. COUNTY

monty

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cherry Chase

d. STREET ADDRESS

4614 Harrison st

10. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Janet Robinson

First Middle Last

Markes

4. DATE OF DEATH

Month

Sept

Day

6

Year

1960

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

11-1-1899

9. AGE (In years last birthday)

60 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edw. Robinson

14. MOTHER'S MAIDEN NAME

Irma Parvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Char Markes (husband)

Address

Stur...

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

120.1 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

Coronary occlusion hypertension

INTERVAL BETWEEN ONSET AND DEATH

sudden

5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year. Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Bloeschart

M.D.

ASSISTANT MEDICAL EXAMINER

☐

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. BLOESCHART

DEPUTY MEDICAL EXAMINER

☒

Address (Street, city, town, or county)

9-6-60

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9-9-1960

22c. NAME OF CEMETERY OR CREMATORY

Rock Creek Cemetery

22d. LOCATION (City, town, or country)

Washington, D.C.

23. FUNERAL DIRECTOR

Joseph Lawrence Smothers 1756-Pa. Ave. NW

ADDRESS

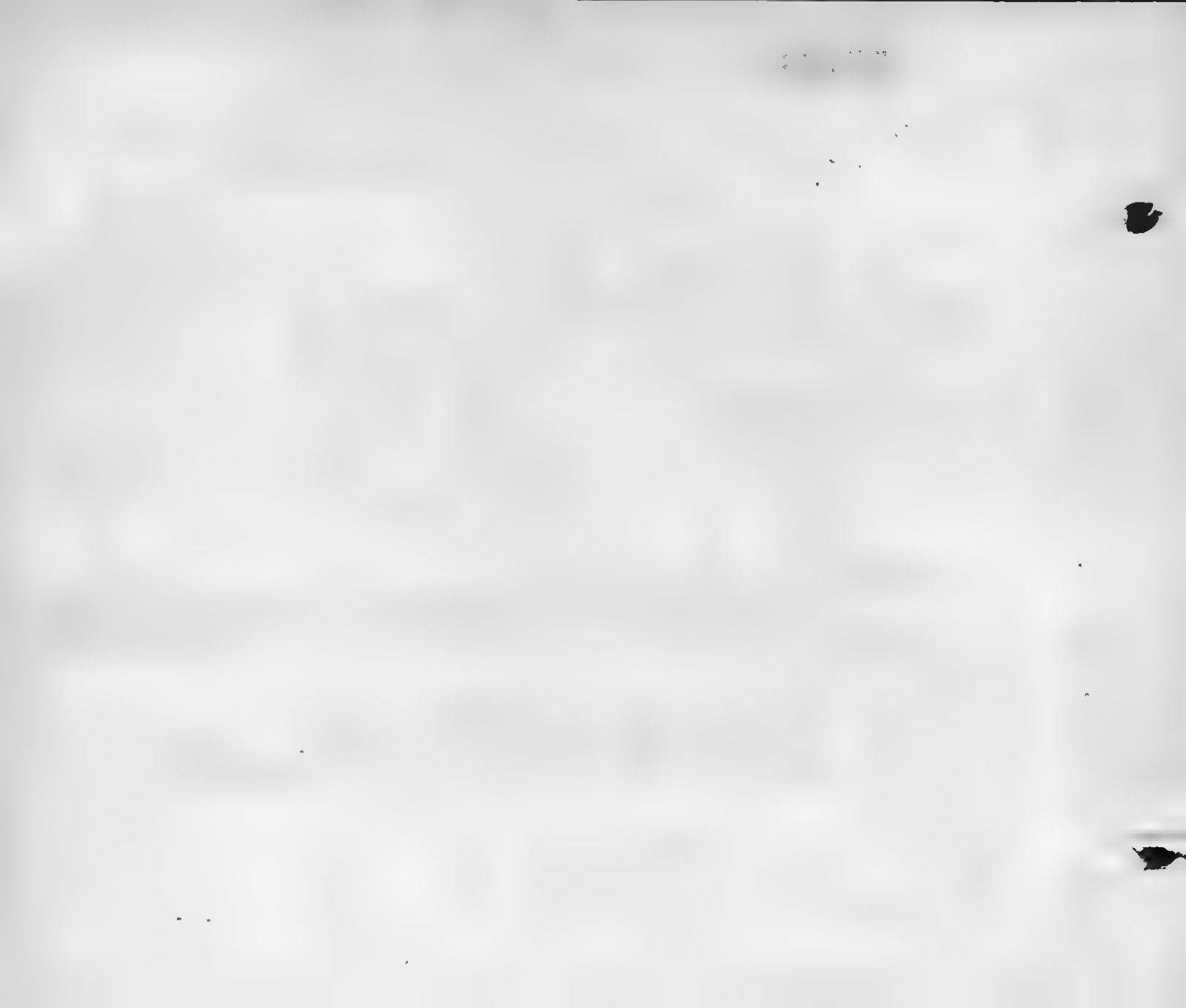
Wash. D.C.

24a. REC'D BY REGISTRAR

SEP 8 '60

24b. REGISTRAR'S SIGNATURE

C. Charles S. House



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10405

CERTIFICATE OF DEATH

10472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1702 CHESAPEAKE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>VINCENT</u> Last <u>MAREAN</u>		4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1968</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.C. FIRE DEPT.</u>	
11. BIRTHPLACE (State or foreign country) <u>COMBESLAND MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RAYMOND P. MAREAN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH POWER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>VIOLA MAREAN-702-CHESAPEAKE ST. ST. SA</u>	
17. INFORMANT <u>VIOLA MAREAN-702-CHESAPEAKE ST. ST. SA</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/10</u> 19 <u>68</u> to <u>9/12</u> 19 <u>68</u> , that I last saw the deceased alive on <u>9/12</u> 19 <u>68</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis X Richardson</u> M.D. <u>11412 VIERS Mill Rd.</u>		DATE SIGNED <u>9/12/68</u>	
PHYSICIAN'S NAME (Type) <u>FRANCIS X RICHARDSON</u>		<u>Washington Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-15-68</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Airy</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lincoln J. Harrison</u> ADDRESS <u>2531 New Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '68</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. King</u>	

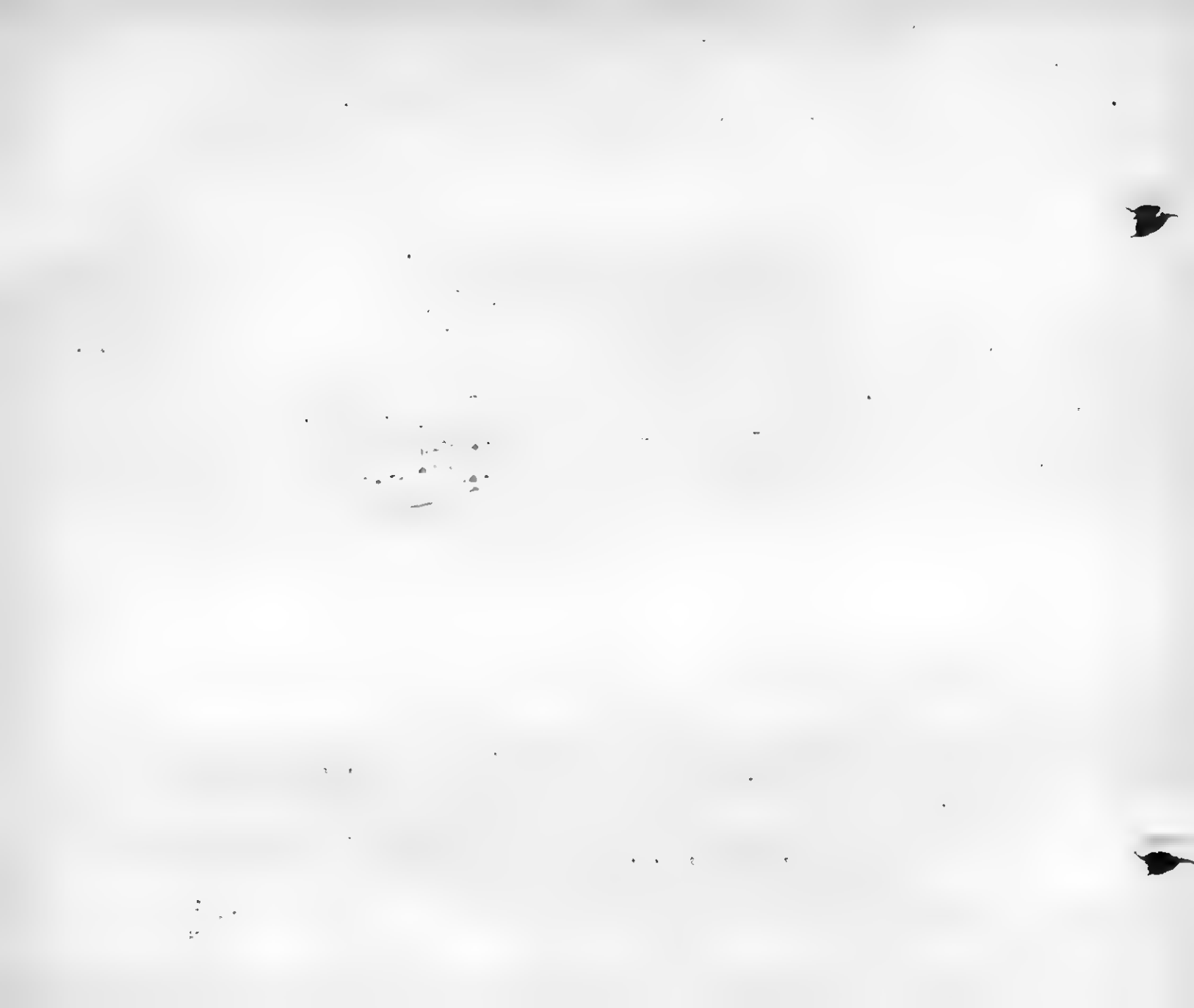
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10517

10473

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Pennsylvania b. COUNTY Delaware			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 7020 Guilford Road			
3 NAME OF DECEASED (Type or print) First William Middle Oscar Last Marrin, Jr.				4. DATE OF DEATH Month September Day 13, Year 19 60			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 3, 1918	9 AGE (In years lost birthday) 42 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Artist		10b. KIND OF BUSINESS OR INDUSTRY Printing		11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William O. Marrin				14 MOTHER'S MAIDEN NAME Bertha Sittler			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO (If yes, give year or dates of service) World War II 167-18-6818		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Calcified Aortic Stenosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from September 11, 1960 to September 13, 1960 , that (I) (we) last saw the deceased alive on Sept. 13, 1960 , and that death occurred at 3:02 p.m. from the causes and on the date stated above							
22a SIGNATURE Benson R. Wilcox, M.D.				22b. DATE SIGNED 9/14/60			
22c PHYSICIAN'S NAME (Type) Benson R. Wilcox, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a BURIAL, CREMATON, REMOVAL (Specify) Burial		23b DATE THEREOF 9/14/60		23c NAME OF CEMETERY OR CREMATORY Montrose Cemetery		23d LOCATION (City, town, or county) (State) Highland Park, Penna.	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a REC'D BY REGISTRAR DATE SEP 15 '60	
				25b REGISTRAR'S SIGNATURE <i>Wilcox & Pumphrey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10518
10474
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Pennsylvania b. COUNTY Fayette ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Normalville		d. STREET ADDRESS (No street address)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle (None) Last May		4. DATE OF DEATH Month September Day 2 Year 1960	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1906
9. AGE (In years last birthday) 54 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton May		14. MOTHER'S MAIDEN NAME Lilly Ritnour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 208-07-4216	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancytopenia DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 23, 1960 to September 2, 1960 , that (I) (we) last saw the deceased alive on September 2, 1960 , and that death occurred at 8:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward E. Morse M.D.		22b. DATE SIGNED 9-3-60	
22c. PHYSICIAN'S NAME (Type) EDWARD E. MORSE, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 9-3-60	
23c. NAME OF CEMETERY OR CREMATORY Normalville Cemetery		23d. LOCATION (City, town, or county) (State) Fayette County, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR SEP 7 '60	
ADDRESS BETHESDA, MD.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

105

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10475

Reg. Dist. No.

FOR STATE
HEALTH-DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>5 DAYS</u>		d. STREET ADDRESS <u>5314 Glenwood Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NETTIE JUNE</u> Middle <u>MC ACHON</u> Last <u></u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>4</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/83</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR <u>11</u> Months <u>26</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY ASCUE</u>		14. MOTHER'S MAIDEN NAME <u>MARY CATHERINE REDWINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>DAUGHTER (MRS. CATHERINE SHREEVE)</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Peripheral phlebitis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Fracture, neck, right femur</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Unknown</u> <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary + Intestinal Tuberculosis, Bilateral confluent bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fall on bed room floor at home</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>5:30 am 8-29-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochart</u>		DATE SIGNED <u>9-4-60</u>	
NAME (Type) <u>FRANK J. BROCHART</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-7-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

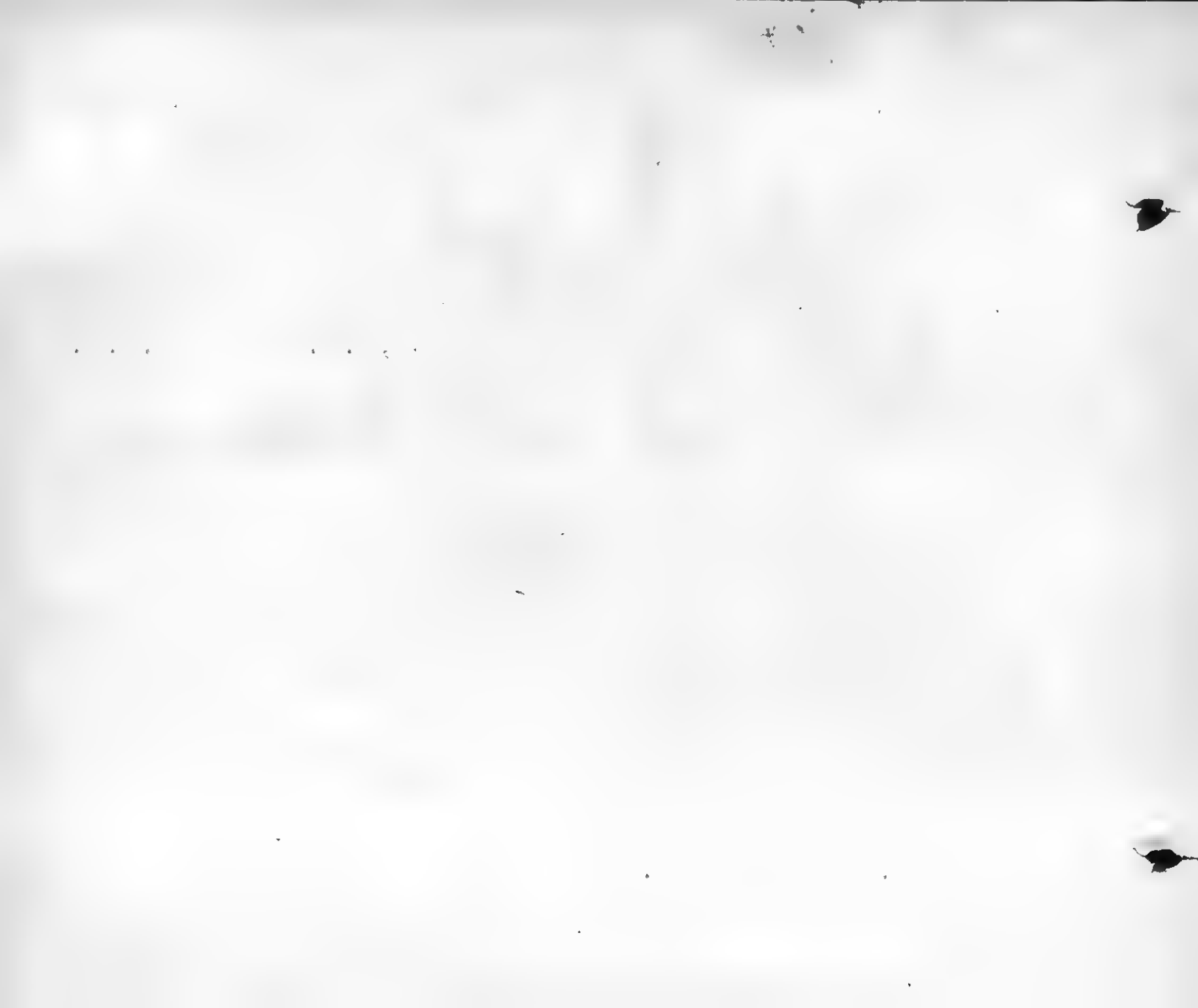
10520

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 35 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				d. STREET ADDRESS 5610-31st Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Wayne Last McGinthy				4. DATE OF DEATH Month September Day 19 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1956	9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months 4 Days 19 Hours 60 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Archie McGinthy				14. MOTHER'S MAIDEN NAME Margaret Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central nervous system leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphatic leukemia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months 21 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 15, 1960 to September 19, 1960 that I last saw the deceased alive on September 19, 1960 and that death occurred at 10:45 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Walter Oppelt				M.D. The Clinical Center, National DATE SIGNED 9/19/60			
PHYSICIAN'S NAME (Type) W. Walter Oppelt, M.D.				Institutes of Health, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/60		22c. NAME OF CEMETERY OR CREMATORY Fort Green		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.				ADDRESS Mt. Rainier Md.		24a. REG. BY REGISTRAR DATE SEP 22 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

10521
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10477

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfax d. STREET ADDRESS 338 Jean Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patricia MC NABB		4. DATE OF DEATH Month Day Year September 23 1960	
5 SEX Female	6 COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-60
9 AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 2	11. IF UNDER 24 HRS yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Michael MC NABB		14. MOTHER'S MAIDEN NAME Mary Evelyn FULLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address (F) Jos. M. McNabb, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO Hyland membrane disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) exhaustion		INTERVAL BETWEEN ONSET AND DEATH 6 hr. 40 hr. 44 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) exhaustion		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (the doctor) attended the deceased from Sept. 21, 1960 12:20PM to Sept. 23, 1960 that (I) did not see the deceased alive on Sept. 23, 1960 and that death occurred at M , from the causes and on the date stated above			
22a. SIGNATURE Laurence G Thorne 22c. PHYSICIAN'S NAME (Type) L. G. THORNE, LT, MC, USN		22b. DATE 9-23-60 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-27-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey ADDRESS R. A. Humphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE SEP 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

9VVVVV VVXVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 41 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A11 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10522

CERTIFICATE OF DEATH

10478

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jack Middle Leon Last McNeil, Jr.		4. DATE OF DEATH Month September Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1952
9. AGE (In years last birthday) 7 yrs		10. IF UNDER 1 YEAR Months 7 Days 13 Hours 1 Min.	11. IF UNDER 24 HRS Months 7 Days 13 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack Leon McNeil, Sr.		14. MOTHER'S MAIDEN NAME Barbara Prater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 587.3 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Cystic Fibrosis of the Pancreas DUE TO (c) Birth		INTERVAL BETWEEN ONSET AND DEATH 4 - 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 20, 1960 , to September 23, 1960 , that (I) (we) last saw the deceased alive on Sept. 23, 1960 , and that death occurred 6:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Hugh Evans M.D.		22b. DATE SIGNED 9/24/60	
22c. PHYSICIAN'S NAME (Type) HUGH EVANS, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/60	
23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE 1501 E. Montgomery Ave. - Rockville, Md		25a. REC'D BY REGISTRAR DATE SEP 28 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Hines			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 22 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 8614 Garfield Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8614 Garfield Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Aloise Middle G. Last MELTON		4. DATE OF DEATH Month September Day 23 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1908
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 3 Days 2 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E. Charlton Graves		14. MOTHER'S MAIDEN NAME Roma Corson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Joseph C. Melton-Same Item #2 - Husband		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED September 23, 1960	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/24/1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR SEP 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kirsch	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10480

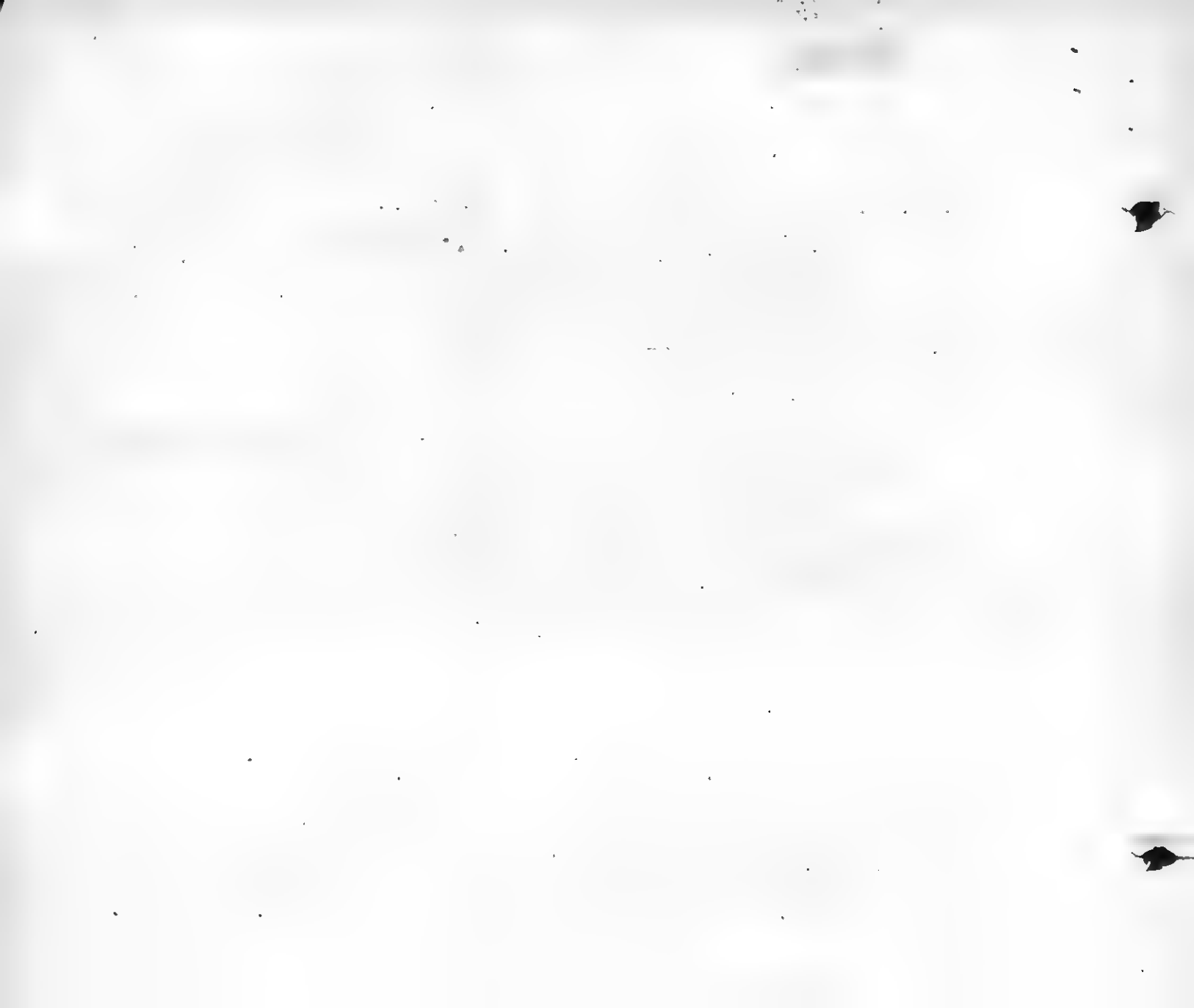
10524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Germantown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Germantown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D.				e. STREET ADDRESS R. F. D.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Albie Middle HENDERSON Last Merrill				4. DATE OF DEATH Month September Day 29 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1873	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 11 Days 29	IF UNDER 24 HRS. Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Tex Texas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William Henderson				14. MOTHER'S MAIDEN NAME Elizabeth Nelson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		Address Mrs. Thomas Kelley-daughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO 450. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolic disease DUE TO Arteriosclerosis (c) 						INTERVAL BETWEEN ONSET AND DEATH 36 hours 1 year 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) advanced senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 					
20c. TIME OF INJURY Month, Day, Year Hour a m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 		
21. I certify that I attended the deceased from Jan 1948 , to Sept 29, 1960 , that I last saw the deceased alive on Sept 29, 1960 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darnestown, Md DATE SIGNED 9/29/60							
ACTUAL SIGNATURE John G. Fawcett		M.D. Darnestown					
PHYSICIAN'S NAME (Type) John G. Fawcett		P. O. Boyd, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/60		22c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		22d. LOCATION (City, town, or county) (State) Darnestown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

MEDICAL CERTIFICATION

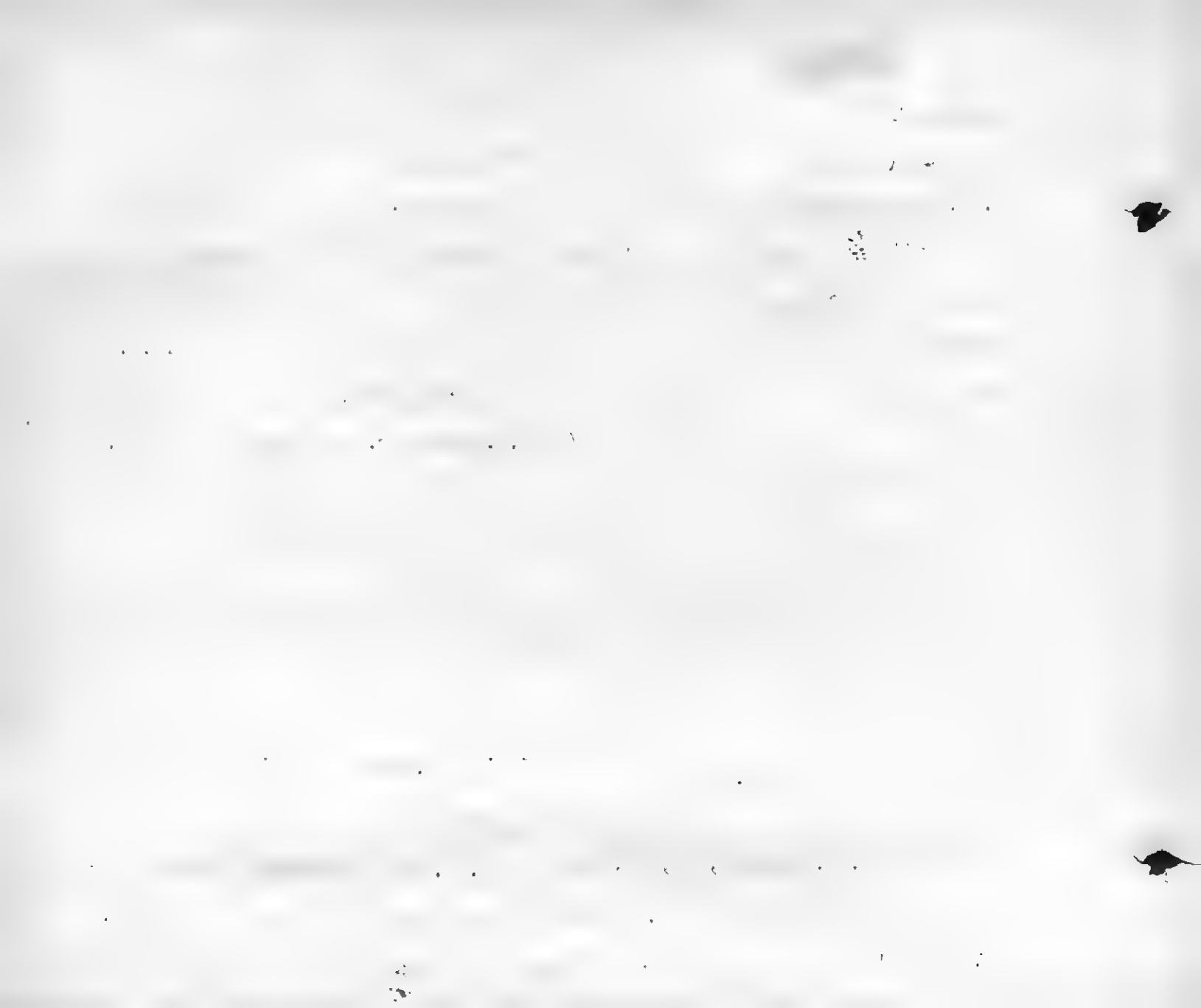


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10525
CERTIFICATE OF DEATH
10481

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Haven		d. STREET ADDRESS 88 Burr St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last MESNER		4. DATE OF DEATH Month September Day 29 Year 1960	
5 SEX Female	6 COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-96
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel REILLY		14. MOTHER'S MAIDEN NAME Cathern CURRAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service) III		16. SOCIAL SECURITY NO	
17. INFORMANT (S) R.G. Mesner, Jr., 117 Commonwealth Ave.		Address Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 23 1960 1:15AM to Sept. 29 1960 , that (X) (we) last saw the deceased alive on Sept. 29 1960 , and that death occurred at 1:15AM M, from the causes and on the date stated above.			
22a. SIGNATURE F. M. Highley, Lt, MC, USN		22b. DATE SIGNED 9-29-60	
22c. PHYSICIAN'S NAME (Type) F. M. HIGHLEY, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-30-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY St. Lawrence's Cemetery		23d. LOCATION (City, town, or county) (State) New Haven Conn.	
24. FUNERAL DIRECTOR'S SIGNATURE Joe Gawler's & Sons, 1756 Penn. Ave, NW, WashDC		25a. REC'D BY REGISTRAR SEP 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Frank			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10526

10483

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 3907 Isbell St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lena Middle Meyrowitz Last Meyrowitz		4. DATE OF DEATH Month Sept. Day 16 Year 1960	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/85
9 AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME Friedman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Leon Meyrowitz Address 3907 Isbell St. Silver Sp. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thromboembolic Disease (CVA 1 month) 4 - 3 X DUE TO Right iliac artery (1 week) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Cardiovascular Disease DUE TO (c) 15 years		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from April 1960 to Sept 16 1960 that (I) (we) last saw the deceased alive on Sept 16 1960 and that death occurred at 3:45 M, from the causes and on the date stated above.			
22a. SIGNATURE Morris Perry M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Morris Perry, M.D.		22d. ADDRESS 11602 Georgia Ave., Wheaton, Maryland	
23a. BURIAL OR CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept 18, 1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) (State) New York City N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE B. Langenickelson ADDRESS 3501-14 St. N.W.		25a. REC'D BY REGISTRAR SEP 21 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Harris			

CERTIFICATE OF DEATH

Reg. Dist. No.

10484

10451

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON</i>		c. LENGTH OF STAY IN TOWN <i>1 year</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Prince George's</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHEVY CHASE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Le Deau Gardens (Home)</i>		d. STREET ADDRESS <i>5122 PIARGLEN LANE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>N.</i> Last <i>Mitholland</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>3</i> Year <i>1960</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/3/03</i>		9. AGE (In years last birthday) <i>56</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TELEPHONE OPERATOR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ANSWERING SERVICE</i>		11. BIRTHPLACE (State or foreign country) <i>GARRETT PARK, MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>EPPA NORRIS</i>				14. MOTHER'S MAIDEN NAME <i>LULA LASKEY</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>Yes-530-1985</i>		17. INFORMANT Address <i>Mr. Eppa L. Norris, 5425 Conn. Ave., N.W.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cholangiolitis hepatitis</i> DUE TO <i>2 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Viral hepatitis</i> DUE TO <i>5 years</i> (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pyelonephritis, Cachexia</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <i>Nov 28, 1957</i> to <i>August 1960</i> that I last saw the deceased alive on <i>July 28, 1960</i> , and that death occurred at <i>8:40 PM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Allen J. O'Neill</i>		M.D. <i>8601 Old Georgetown Rd</i>		ADDRESS (Street, city or town, state)		DATE SIGNED <i>9/4/1960</i>			
PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		<i>Bethesda 14 Md</i>							
22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>9/6/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>GLENWOOD CEMETERY</i>		22d. LOCATION (City, town, or county) <i>WASHINGTON, D.C.</i>		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Bumprey, Inc.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>SEP 7 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Clifton S. Harris</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Can be used with coroner and approved.

TELEPHONE OPERATOR

EPVA NORRIS

NO

Yes -

Mr. Epva L. Norris, 2425 Conn. Ave., N.W.
Washington, D.C.

LULA LASKY

ANSWERING SERVICE GARRETT PARK, MARYLAND U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M III/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10527

10485

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grovet Park</u>	
		d. STREET ADDRESS <u>11123 Rokeby Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rita</u> Middle <u>Mary</u> Last <u>Millard</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 19, 1920</u>
9. AGE (In years last birthday) <u>39 yrs</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
11. IF UNDER 24 HRS Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Dakota</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Messing</u>		14. MOTHER'S MAIDEN NAME <u>Rose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT (Husband) <u>Robert Millard</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic coma</u> DUE TO (b) <u>Metastatic carcinoma breast</u> DUE TO (c) <u>18 mos</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> <u>1960</u> , to <u>27 Aug</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>26 Aug</u> <u>1960</u> and that death occurred at <u>2:30</u> <u>PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Horace W. Bernton</u>		22b. DATE SIGNED <u>27 Aug '60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>		22d. ADDRESS <u>10511 Summit Ave. Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 30 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Himes</u>	

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10528

10486

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b 71 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) Planmfield		d. STREET ADDRESS Planmfield	
3. NAME OF DECEASED (Type or print) WILLIAM WILSON MOORE		4. DATE OF DEATH Month 9 Day 11 Year 1960	
5. SEX M	6. CO. OR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1888
9. AGE (In years lost birthday) 71 yrs		IF UNDER 1 YEAR Months 7 Days 11 Hours 19 Min. 60	IF UNDER 24 HRS. Months 7 Days 11 Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchardist		10b. KIND OF BUSINESS OR INDUSTRY Orchard	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZENSHIP OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Rowland Moore		14. MOTHER'S MAIDEN NAME Margaret G. Tyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) No		16. SOCIAL SECURITY NO. 20-348461	
17. INFORMANT Helen W. Moore		Address Sandy Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal hemorrhage DUE TO Obstructive jaundice DUE TO Carcinoma of head of pancreas DUE TO Cholera		INTERVAL BETWEEN ONSET AND DEATH 6 wks 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholera			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 5, 1960 to 9/11/60 , that (I) (we) last saw the deceased alive on 9/11/60 , and that death occurred on 9/11/60 M. from the causes and on the date stated above.			
22a. SIGNATURE C. H. LIGAN		22b. DATE SIGNED 9/12/60	
22c. PHYSICIAN'S NAME (Type) C. H. LIGAN		22d. ADDRESS SANDY SPRING, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City, town, or county) (State) Greenwood, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James E. Moore		25. REC'D BY REGISTRAR DATE SEP 14 '60	
ADDRESS 1331-F N. W. 1st St. Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur E. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
7
16529
MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10487
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 4740 Bradley Blvd.	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Sylvester Morningstar		4. DATE OF DEATH Month Day Year Sept. 11 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/10
9. AGE (in years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Shoeham Hotel	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Algia Morningstar		14. MOTHER'S MAIDEN NAME Fannie M. Orme	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 2-4-67-7384	
17. INFORMANT Alice Morningstar/ Same as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure			
DUE TO Cerebrovascular disease			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Plumetis with affection, right			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/8 Sept 1960 , to 11 Sept 1960 , that (I) (we) last saw the deceased alive on 11 Sept 1960 , and that death occurred at 9:15 PM , from the causes and on the date stated above			
22a. SIGNATURE Robert Young		22b. DATE SIGNED 9/11/60	
22c. PHYSICIAN'S NAME (Type) ROBERT YOUNG		22d. ADDRESS 4740 Bradley Blvd. Ch. Ch. 15 Md	
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF 9/15/60	
23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City, town or county) (State) Bethesda Md	
24. FUNERAL DIRECTOR'S SIGNATURE Lynn Wheeler		25a. REC'D BY REGISTRAR SEP 14 1960	
ADDRESS 1331 E Montgomery		25b. REGISTRAR'S SIGNATURE C. L. H. H. H.	

TO HC, AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled
out, it must be given to the funeral director.

Page 1 of 1

by the funeral director,
who should be filed in the

10489

10437

MEDICAL CERTIFICATION

The State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10489

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scholar</u> c. LENGTH OF STAY IN b. <u>8 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chelmsford Rd. English Manor</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>143 Oswego Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Walker Mosley</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bulldozer operator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u> 11. BIRTHPLACE (State or foreign country) <u>WINFIELD LA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>		4. DATE OF DEATH <u>Sept 27 1960</u> 8. DATE OF BIRTH <u>5-1-1905</u> 9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>	
13. FATHER'S NAME <u>JIM MOSLEY</u> 14. MOTHER'S MAIDEN NAME <u>NANCY MC WRIGHT</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>21091478</u> 17. INFORMANT <u>LORETTA MOSLEY</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Unknown</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>0</u> p.m. <u>0</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-28-60</u> Address (Street, city, town, or county) (State)			
ACTUAL SIGNATURE <u>Frank J. Bioschalt</u> EXAMINER'S NAME (Type) <u>FRANK J. Bioschalt</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/1/60</u> 22b. DATE THEREOF <u>10/1/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>National Harmony</u> 22d. LOCATION (City, town, or country) (State) <u>Prince George's Maryland</u>	
23. FUNERAL DIRECTOR <u>John T. Rhines & Co.</u> ADDRESS <u>3015-12th St. N.E.</u>		24a. REC'D BY REGISTRAR <u>SEP 30 '60</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10490

10424

CERTIFICATE OF DEATH

Reg. Dist. No.

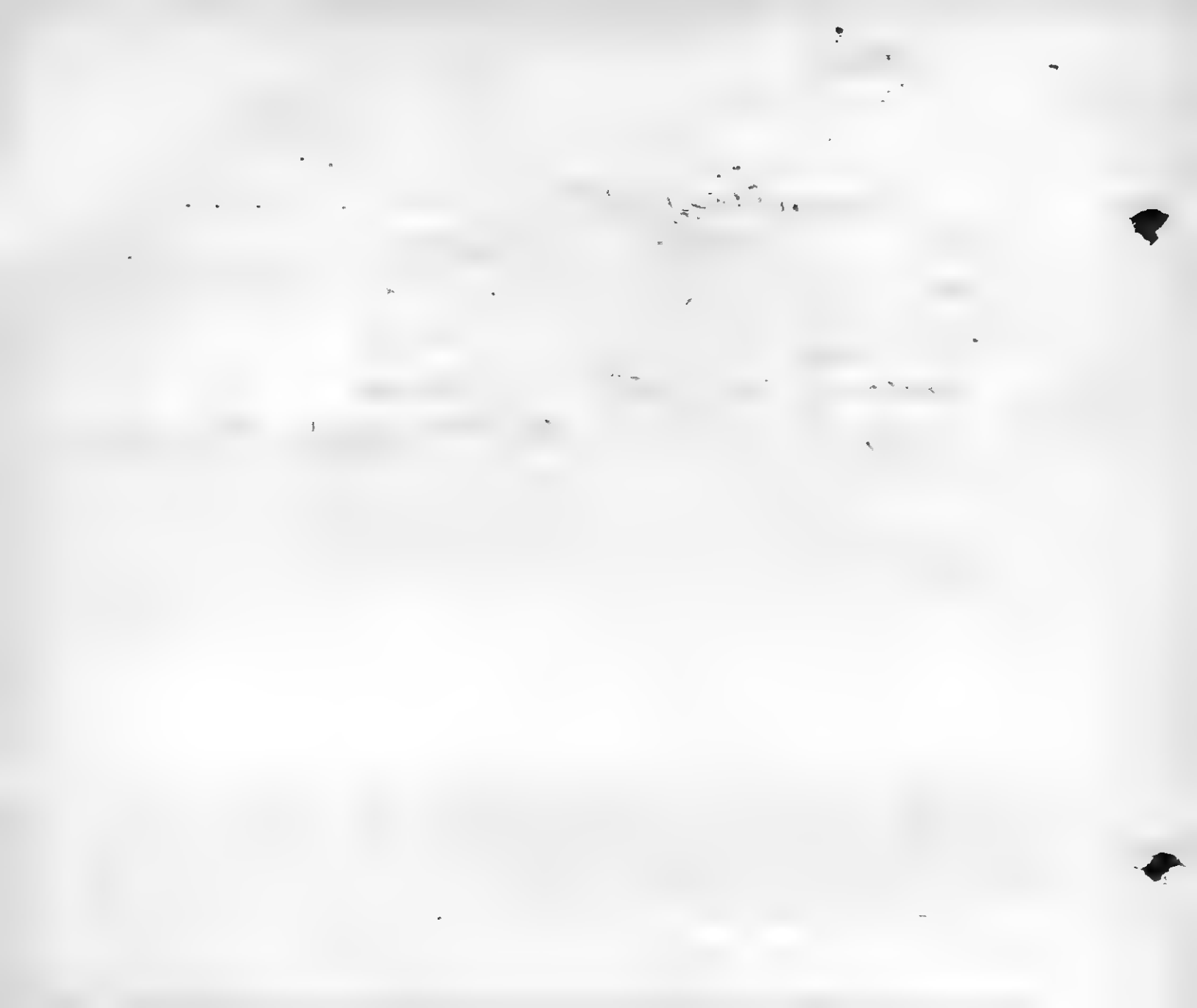
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 days.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>32 Mississipp Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marquette Ashby Motte</u> First Middle Last		4. DATE OF DEATH <u>Sept 6 1960</u> Month Day Year	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-00</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dep't. Port Rptd N. Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred B Diew</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Newton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1750 Congestive Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma - Ovarian</u> DUE TO (c) <u>1958</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminx.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>60</u> , to <u>Sept. 6</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 6</u> 19 <u>60</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.		ADDRESS (Street, city or town, state) <u>1600 Carroll Ave, T.P. Md.</u> DATE SIGNED <u>9/6/60</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept. 9, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George's County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		ADDRESS <u>254 Carroll St. Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>SEP 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	



CERTIFICATE OF DEATH

11491

1. PLACE OF BIRTH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>District of Columbia</i> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>4917 42nd St., Wash., D.C.</i>	
3. NAME OF DECEASED (Type or print) First <i>Peter</i> Middle <i>muscato</i> Last <i>jr.</i>		4. DATE OF DEATH Month <i>9</i> Day <i>26</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/19/83</i>
9. AGE (In years last birthday) <i>77</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Anthony J. muscato</i>		14. MOTHER'S MAIDEN NAME <i>Anna ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO <i>015-16-2804</i>	
17. INFORMANT <i>Rose M. Bonfigliolo (Daughter)</i>		Address <i>4917 42nd St. Washington, DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>UREMIA (NEPHROTIC SYNDROME)</i> DUE TO (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO (c) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1+ WEEK</i> <i>1+ YRS</i> <i>10+ YRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>JAN. 1957</i> to <i>9/26</i> , 1960, that (I) (we) last saw the deceased alive on <i>9/25</i> , 1960, and that death occurred at <i>5:45</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles Savarino M.D.</i> M.D.		22b. DATE SIGNED <i>9/26/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>CHARLES SAVARINO, M.D.</i>		22d. ADDRESS <i>4800 BATTERY LANE BETHESDA, MD</i>	
23a. BURIAL, CREMATION, REMOVA- (Specify) <i>burial-transit</i>		23b. DATE THEREOF <i>9-29-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Bernards Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Concord, Massachusetts</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i> ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 27 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Harris</i>			



CERTIFICATE OF DEATH

Reg. Dist. No.

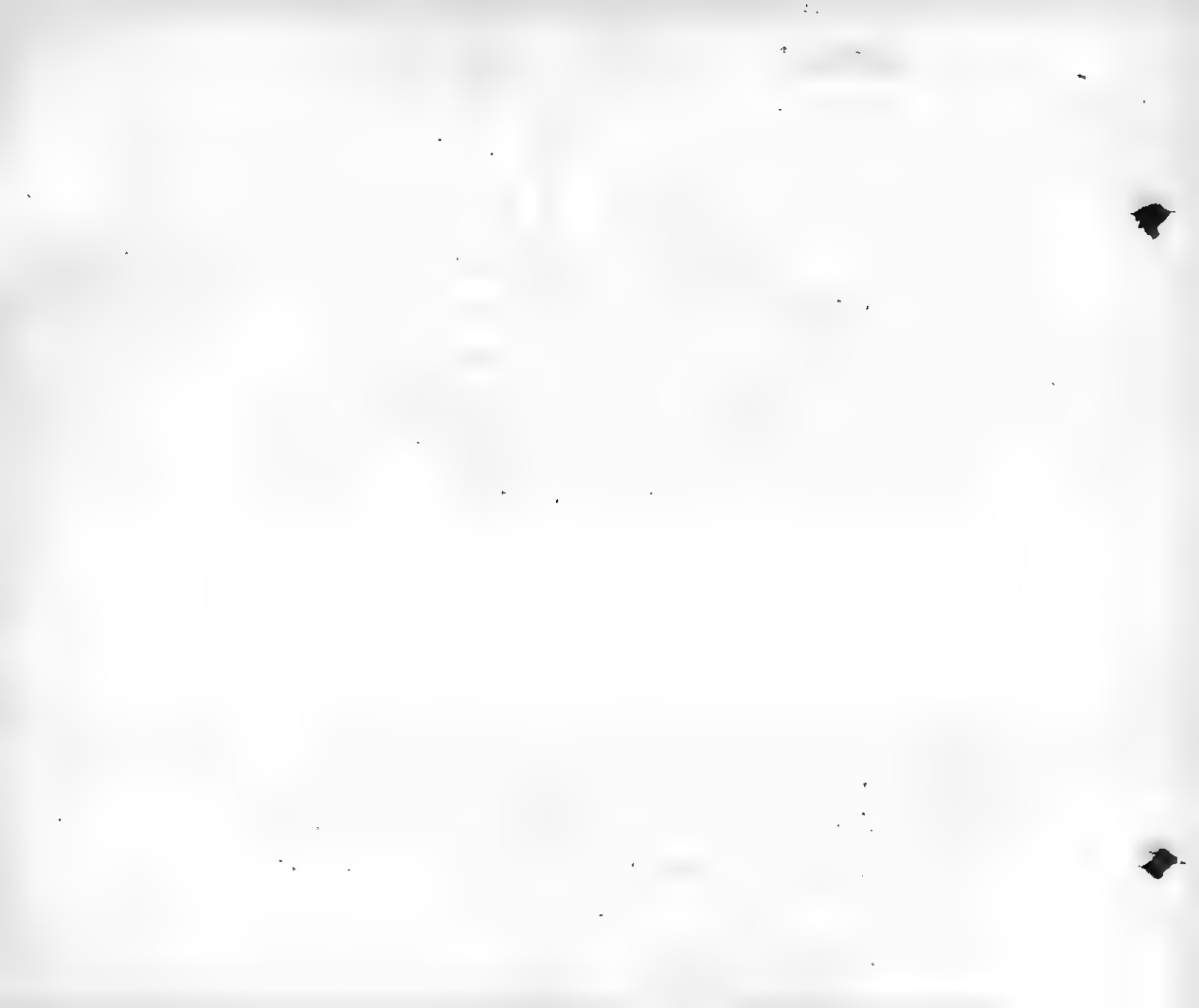
10492

10532

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. STREET ADDRESS <u>11511 Monongahela Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>NEJAKO</u>		4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/60</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>2</u> Min <u>2</u>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Mark E. Nejak</u>	
14. MOTHER'S MAIDEN NAME <u>Nancy J. Rinker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT Address <u>parents</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 17, 1960</u> to <u>Sept. 17, 1960</u> that I last saw the deceased alive on <u>Sept. 17, 1960</u> , and that death occurred at <u>8:09 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen C. Cromwell</u> M.D.		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Avenue</u> DATE SIGNED <u>9/17/60</u>	
PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>		<u>Rockville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Rumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 20 1960</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.
M
TO DELIVERY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10493

10425

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN IL 5 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Takoma Park		d. STREET ADDRESS 505 Tulip Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Edgar New		First		Middle		Last		4. DATE OF DEATH Sept 10 1960		Month		Day		Year	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/1869		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) nl.		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Wm. W. New		14. MOTHER'S MAIDEN NAME Susan Stickman													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Henrietta E. New (wife)		Address Item 2									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death fell dead on kitchen floor												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 9/11/60		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 13, 1960		22c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK		22d. LOCATION (City, town, or country) FALLS CHURCH, VA									
23. FUNERAL DIRECTOR'S NAME (Type) John J. Hall		ADDRESS WASHINGTON 12, D.C.		24a. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10494

10533

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Dist. of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 80 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 3945-Conn. Ave. N.W. Apt 4 08		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen T. Noren				4. DATE OF DEATH Sept. 16, 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1890	
9. AGE (In years lost birthday) 69 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY C.I.A.		11. BIRTHPLACE (State or foreign country) Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Frank Noren		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Yes		17. INFORMANT Nephew Verele Lyberg		18. ADDRESS 1421 Arch St. Phila., Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac failure 42001 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 weeks DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MED. EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-4-55 to 9-16-60 , that (I) first last saw the deceased alive on 9-16-60 , and that death occurred at 6:52 P.M. from the causes and on the date stated above							
22a. SIGNATURE C. Roger Runtz				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-16-60	
22c. PHYSICIAN'S NAME (Type) C. Roger Runtz				22d. ADDRESS 3600 Connechee Avenue Wash. DC			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-17-60		23c. NAME OF CEMETERY OR CREMATORY Hill Side Cemetery		23d. LOCATION (City, town, or county) (State) Minneapolis, Minn.	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR SEP 20 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15 (4)
ISM 9/59

10534
10495
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Cherry Chase</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Veronica O'Connor</u>		4. DATE OF DEATH Month Day Year <u>Sept 8 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-88</u>
9. AGE (In years lost birthday) <u>72 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1 27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Cummer</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Eunice McDonald-Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure - acute</u> DUE TO <u>161.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Massive Hemorrhage</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> to <u>9-8</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9-8</u> 19 <u>60</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>James H. Scully</u>		22b. DATE SIGNED <u>9/8/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Scully, M.D.</u>		22d. ADDRESS <u>1835 I St. N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/12/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



Reg. Dist. No.

10496

10496

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8709 Plymouth St.</u>		2. USUAL RESIDENCE (When deceased lived in institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>18709 Plymouth St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kaemon OKUMURA</u> First Middle Last 4. DATE OF DEATH <u>SEPT. 25 1960</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OF EYES <u>YELLOW</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 2 1896</u> 9. AGE (In years last birthday) <u>64</u> yrs 10. IF UNDER 1 YEAR: Months Days Hours Min. 11. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEF</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> 11. BIRTHPLACE (State or foreign country) <u>Japan</u> 12. CITIZEN OF WHAT COUNTRY? <u>Japan</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>WIFE Frank KUGA (FRIEND)</u> Address <u>—</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, Chronic</u> DUE TO (b) <u>Hypertension and Coronary Arteriosclerosis</u> DUE TO (c) <u>Heart Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1957</u> to <u>Sept 25 1960</u> that I last saw the deceased alive on <u>Sept 20 1960</u> and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1835 EYE ST N.W.</u> DATE SIGNED <u>William S. Miller</u> ACTUAL SIGNATURE <u>William S. Miller</u> M.D. <u>Frank C. D.C.</u> PHYSICIAN'S NAME (Type) <u>William S. Miller, M.D.</u> <u>Frank C. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION 9/29/60</u> 22b. DATE THEREOF <u>9/29/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM</u> 22d. LOCATION (City, town, or county) (State) <u>P.R. GR. CO. MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W.R. Henderson</u> ADDRESS <u>573 L</u> 24a. REC'D BY REGISTRAR <u>SEP 28 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

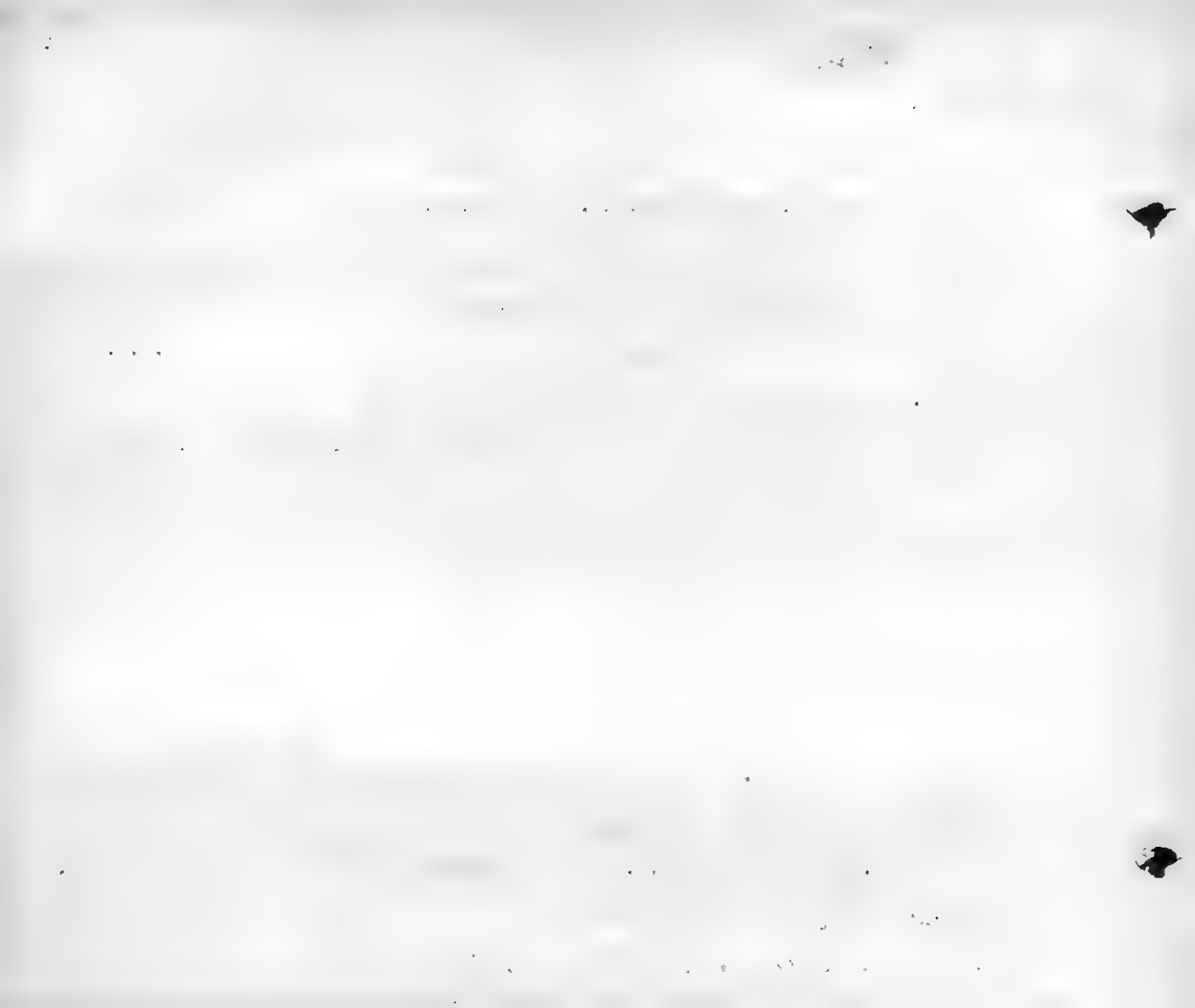
VR A15 (4)
15M 9/59

10535

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10497

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) STATE Virginia b. COUNTY Accomack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Onancock	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 100 Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle Mae Last Payne		4. DATE OF DEATH Month September Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1903
9. AGE (In years lost birthday) 57 yrs		IF UNDER 1 YEAR: Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred B. Booth		14. MOTHER'S MAIDEN NAME Elizabeth Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple myeloma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 25 , 19 60 , to September 28 , 19 60 that (I) (we) last saw the deceased alive on Sept. 28 , 19 60 , and that death occurred at 7:53AM from the causes and on the date stated above			
22a. SIGNATURE W. Walter Oppelt, M.D.		22b. DATE SIGNED 9/28/60	
22c. PHYSICIAN'S NAME (Type) W. Walter Oppelt, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, or OTHER (Specify) Burial		23b. DATE THEREOF 9/30/60	
23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City, town, or county) (State) Chincoteague, Va	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Williams		25a. REC'D BY REGISTRAR SEP 30 '60	
ADDRESS ONANCOCK, Va		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director, by the funeral director, and completely filled in. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10407
10498
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADLINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ALTEA GLEN HOSPITAL</u>		d. STREET ADDRESS <u>220 N. KELCRE ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ABEL</u> <u>POTTER</u> <u>DAYE</u>		4. DATE OF DEATH Month Day Year <u>9/17/60</u> <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1867</u>
9. AGE (In years last birthday) <u>93</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H. POTTER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH VAIL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>CAPT. THOMAS L. DAYE, 4109</u>		Address <u>FOOT T L. E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jun 1959</u> to <u>Sept 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 15 1960</u> and that death occurred at <u>100 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.		22b. DATE SIGNED <u>9-17-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 UNIVERSITY BLVD., S. S., MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>9/10/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		23d. LOCATION (City, town or county) (State) <u>SEITLAND, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Saviers Sons</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 21 '60</u>	
ADDRESS <u>1755 D. AVE. NW DC</u>		25b. REGISTRAR'S SIGNATURE <u>Walter S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

10536

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10499

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 150 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1435 Sheridan Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle Ivan Last Perlow			4. DATE OF DEATH Month September Day 7 Year 19 60								
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1943		9 AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Sydney Perlow				14. MOTHER'S MAIDEN NAME Bertha Sager							
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16 SOCIAL SECURITY NO. None		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO 1977.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain Stem Compression of Fibrosarcoma DUE TO (c) 2 years INTERVAL BETWEEN ONSET AND DEATH 2 hrs.											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from April 10, 1960 to September 7, 1960 , that (I) (we) last saw the deceased alive on September 7, 1960 , and that death occurred on September 7, 1960 at 12:35 AM from the causes and on the date stated above.											
22a SIGNATURE Philip J. Ferris, M.D.				22b ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				22c PHYSICIAN'S NAME (Type) Philip J. Ferris, M. D.			
22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				22e ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22f DATE SIGNED 9/7/60			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town, or county)		23e (State)			
Burial		9-8-60		B'nai Israel Cemetery		Oxon Hill, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons				ADDRESS 3501 14th St., NW				25a REC'D BY REGISTRAR SEP 9 '60		25b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10537

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10500

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) 9 STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>9d. ys-9 hours</u>		d. STREET ADDRESS <u>3031 Nash P lace, S. E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Free burban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>L</u> Last <u>Perry</u>		4. DATE OF DEATH Month <u>Sep t.</u> Day <u>9</u> Year <u>1960</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/04</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11 BIRTHPLACE (State or foreign country) <u>Bethesda, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Benjamin Perry</u>		14. MOTHER'S MAIDEN NAME <u>Annie Brewer</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. J. Wilbert Perry</u>		Address <u>3031 Nash P lace, Wash, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli, bilateral</u> b. <u>Peripheral thrombophlebitis (legs)</u> c. <u>Cellulitis of foot</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>2 wks</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) <u>this hospital</u> attended the deceased from <u>July</u> 19 <u>60</u> to <u>Sept. 9</u> 19 <u>60</u> that (I) <u>met</u> last saw the deceased alive on <u>Sept. 9</u> 19 <u>60</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Roger Kurtz</u> M.D.		22b. DATE SIGNED <u>9-9-60</u>	
22c PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz M.D.</u>		22d. ADDRESS <u>3031 Connecticut Ave. N.W.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>9/13/60</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 14 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Kneass</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

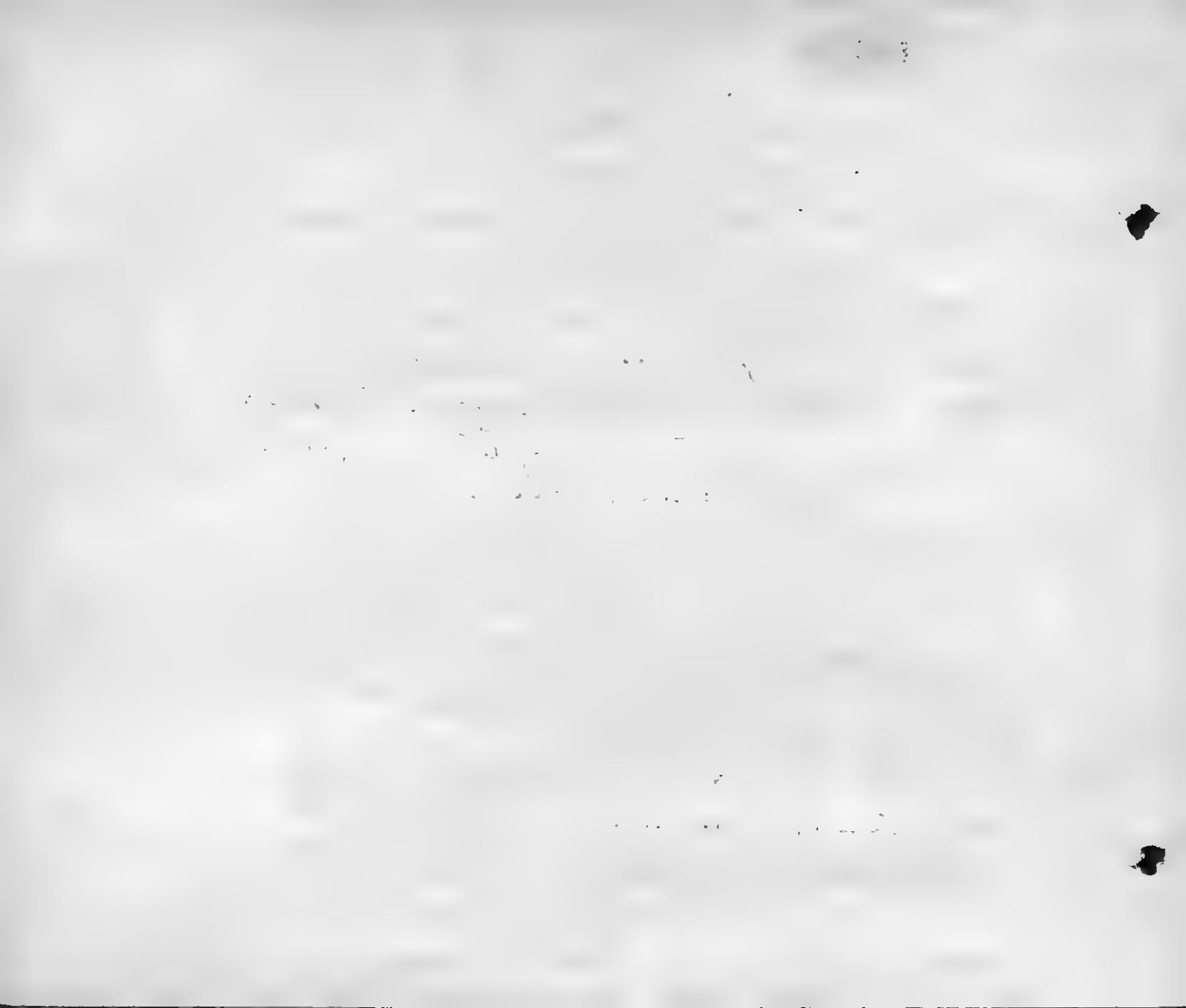
VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10501

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase - 15</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase - 15</u>	
c. LENGTH OF STAY IN 1b <u>9 yrs</u>		d. STREET ADDRESS <u>6208 Highland Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wallace Francis Peterson</u>		4. DATE OF DEATH <u>Sept 14 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-26-1908</u>	
9. AGE (In years, last birthday) <u>51</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Utah</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>M.S.C</u>	
13. FATHER'S NAME <u>Peter Peterson</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Jay Peterson (wife)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-16-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ROCKVILLE, MONTGOMERY Co., MD</u>	
23. FUNERAL DIRECTOR <u>Joseph Gaudin's Sons, Inc. Wash. DC</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u>		DATE SIGNED <u>9-14-60</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10452

CERTIFICATE OF DEATH

10522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL SANITARIUM				d. STREET ADDRESS 10231 CARROLL PLACE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CARRIE First J. Middle PROCTOR Last				4. DATE OF DEATH Month SEPT. Day 11 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-1871	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME CHARLES GWYNNE				14. MOTHER'S MAIDEN NAME MARIA PRESTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT STUART E. PROCTOR Address (Son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION							INTERVAL BETWEEN ONSET AND DEATH 24 HRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 5 , 19 59 , to SEPT. 11 , 19 60 , that I last saw the deceased alive on SEPT. 11 , 19 60 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Neuzen Lowden M.D.				ADDRESS (Street, city or town, state) 5206 Norway Dr.		DATE SIGNED 9/11/60	
PHYSICIAN'S NAME (Type) Cheney Chase, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-13-1960		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY WASHINGTON, D.C.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawkins Sons ADDRESS 1750 H. and Wash. D.C.				24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10426

10543

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>20 minutes</u>				d. STREET ADDRESS <u>6616 Gude Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arby</u> Middle <u>Clifton</u> Last <u>Pyles</u>				4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1907</u> <u>July 20 1919</u>	9. AGE (In years last birthday) <u>51</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Government</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Pyles</u>				14. MOTHER'S MAIDEN NAME <u>Anna Tucker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War 2</u>				16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Washington Sanatorium & Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION WITH MYOCARDIAL FAILURE - 2 TO 4 DAYS.</u> DUE TO (b) <u>CORONARY THROMBOSIS, ACUTE, RIGHT. 2 TO 4 DAYS.</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Aug 19 1960</u> to <u>Aug 31 1960</u> that (I) (we) last saw the deceased alive on <u>Aug 31 1960</u> and that death occurred at <u>4</u> A.M. from the causes and on the date stated above			
22a. SIGNATURE <u>Joseph Serrano MD</u>				22b. ADDRESS		22c. PHYSICIAN'S NAME (Type)	
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE THEREOF <u>9-6-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u>	
23d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Eugene Howe</u>		25a. REC'D BY REGISTRAR <u>SEP 13 60</u>	
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10538

CERTIFICATE OF DEATH

10504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON, MD</u>		c. LENGTH OF STAY IN 1b <u>June 6-1960</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WHEATON NURSING HOME WHEATON, MD</u>				d. STREET ADDRESS <u>724-3rd STREET, N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTINE BEATRICE RABBITT</u>				4. DATE OF DEATH Month Day Year <u>9 20 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 31, 1878</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALFRED G. MCKENSIE</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA GASKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address City <u>MISS LEAH RABBITT-460-W-24th ST. NEW YORK</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO <u>Diabetes Mellitus</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>10 years</u> <u>25 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>January, 1947</u> , to <u>Sept 20, 1960</u> , that I last saw the deceased alive on <u>Sept 11, 1960</u> , and that death occurred at <u>10:58 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Perkins</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>1463-Rock Island Ave NW Wash DC</u> <u>9/20/60</u>			
PHYSICIAN'S NAME (Type) <u>W. ROBERT PERKINS</u>				SAME AS ABOVE			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/23/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Haffner</u>		ADDRESS <u>475-H N. W. Road 1 D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10408

10505

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
c. LENGTH OF STAY IN 1b <u>7 years</u>		d. STREET ADDRESS <u>1100 K Street NE</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>MARILEA Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Ready</u> Last <u>Ready</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1960</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1 1859</u>
9. AGE (If years last birthday) <u>101</u> yrs.		IF UNDER 1 YEAR Months <u>101</u> Days <u>101</u> Hours <u>101</u> Min. <u>101</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Ready</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Walsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>REV. S.R. PITS</u>		Address <u>Georgetown Univ</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic degenerative disease</u> DUE TO (c) <u>Advanced arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>2-14</u> 19 <u>58</u> , to <u>Sept 7</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Sept 6</u> 19 <u>60</u> , and that death occurred <u>5:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John S. Roberts, M.D.</u>		22b. ADDRESS <u>1919 Seminary Rd Silver Spring, Md</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept 10 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>WASH D.C.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
ADDRESS <u>2224 W. 5 Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Rouse</u>	

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10539

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10506

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 25 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		d. STREET ADDRESS 820 Connecticut Ave., N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Holden Middle Chester Last RICHARDSON		4. DATE OF DEATH Month September Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-78
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William RICHARDSON		14. MOTHER'S MAIDEN NAME Elmira J. DOUGHY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI & WWII		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Mrs. Diana RICHARDSON, Same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Cardio-renal disease DUE TO (c) Pneumonia bilateral (staphylococci) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cholecystectomy & cholecystostomy on 8-16-60-		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-5- 1960 to 9-2- 1960 , that (I) (we) last saw the deceased alive on 9-2-60 19, and that death occurred at 6:05AM from the causes and on the date stated above.			
22a. SIGNATURE L. J. Hines		22b. DATE SIGNED 9-2-60	
22c. PHYSICIAN'S NAME (Type) L. J. HINES, CDR, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-7-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Grawler & Son		25a. REC'D BY REGISTRAR SEP 7 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

Wash. D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10597

10540

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Diers Mill Village</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>112315 Middle Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Gerald Kevin Riley</i>		4. DATE OF DEATH Month Day Year <i>Sept 1 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>23 July 1958</i>
9. AGE (In years last birthday) <i>2</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John A. Riley</i>		14. MOTHER'S MAIDEN NAME <i>Madeline Joper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Madeline Riley (Mother)</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Aspiration of gastric contents</i> <i>571.0</i> DUE TO <i>Interacardial Edema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Acute catarrhal colitis</i> DUE TO <i>—</i> DUE TO <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>Sudden</i> <i>4 days</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>23 July 1958</i> to <i>1 September 1960</i> , that (I) (we) last saw the deceased alive on <i>31 August 1960</i> , and that death occurred at <i>3:15</i> M, from the causes and on the date stated above			
22a. SIGNATURE <i>Katharine A. Chapman</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>KATHARINE A. CHAPMAN</i>		22d. ADDRESS <i>3924 Baltimore St., Kensington, Md.</i>	
22b. DATE SIGNED <i>Sept 1, 1960</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-6-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>Bethesda, Md.</i>		25a. REC'D BY REG STRAR <i>SEP 7 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10541

10568

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE ARLINGTON b. COUNTY ARLINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 145 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Virginia		d. STREET ADDRESS 5622 Yorktown Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph Dinsmore ROSS		4. DATE OF DEATH Month Day Year September 18 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-13
9. AGE (In years last birthday) 46 yrs		10. KIND OF BUSINESS OR INDUSTRY Medical Officer	11. BIRTHPLACE (State or foreign country) Kansas
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Officer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Reath ROSS		14. MOTHER'S MAIDEN NAME Mary MUSTARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1938 to DOD		16. SOCIAL SECURITY NO. 509-03-2436	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma, pancreas, with metastases 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 mos.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (the hospital) attended the deceased from April 26 1960 to Sept. 18 1960, that (I) saw the deceased alive on Sept. 18 1960, and that death occurred at 10:50AM M, from the causes and on the date stated above			
22a. SIGNATURE G. I. Walker, Jr.		22b. DATE SIGNED 9-19-60	
22c. PHYSICIAN'S NAME (Type) G. I. WALKER, JR., CAPT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-21-60,	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town, or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 1400 Chapin St., NW, WashDC		25a. REC'D BY REGISTRAR DATE SEP 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 48	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4890 Battery Lane		e. STREET ADDRESS 4890 Battery Lane	
3. NAME OF DECEASED (Type or print) First George Middle Frank Last Royston		4. DATE OF DEATH Month Sept. Day 25 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Express Agency		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Royston		14. MOTHER'S MAIDEN NAME Blanche Popham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW I		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Frances Royston		Address 4890 Battery Lane Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 58 , to Sept. 25 , 19 60 , that I last saw the deceased alive on Sept. 20 , 19 60 , and that death occurred at 10:40 P.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 7733 Alaska Ave. N.W. Washington D.C.		DATE SIGNED 9/25/60	
ACTUAL SIGNATURE Benjamin Isaacson, M.D.		M.D. 7733 Alaska Ave. N.W. Washington D.C.	
PHYSICIAN'S NAME (Type) Benjamin Isaacson		7733 Alaska Avenue, N.W. Wash. DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/60	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Culpeper, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.		24a. REC'D BY REGISTRAR SEP 28 '60	
ADDRESS 2901 14th St., N.W. Washington 9, D.C.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

10543

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY in 1b 26 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSP.		e. STREET ADDRESS Rt. 2	
3 NAME OF DECEASED (Type or print) First Middle Last MARY RUTH RUNYAN		4. DATE OF DEATH Month Day Year SEPTEMBER 12 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/99
9 AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Internal Revenue Agent		10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D. C.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LEE J. RUNYAN		14. MOTHER'S MAIDEN NAME GERTRUDE SCOTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO none	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) INANITION DUE TO INTRAABDOMINAL CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) PRIMARY ARRHENO BLASTOMA OF RIGHT OVARY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1958 to Sept. 12 1960 that I last saw the deceased alive on Sept. 12 1960 , and that death occurred at 10²⁰ A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/12/60			
ACTUAL SIGNATURE Jack Schumacher M.D.		9/12/60	
PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.		GAITHERSBURG, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/15/60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia
23 FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth		ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR DATE SEP 16 '60
		24b. REGISTRAR'S SIGNATURE Carling L. House	

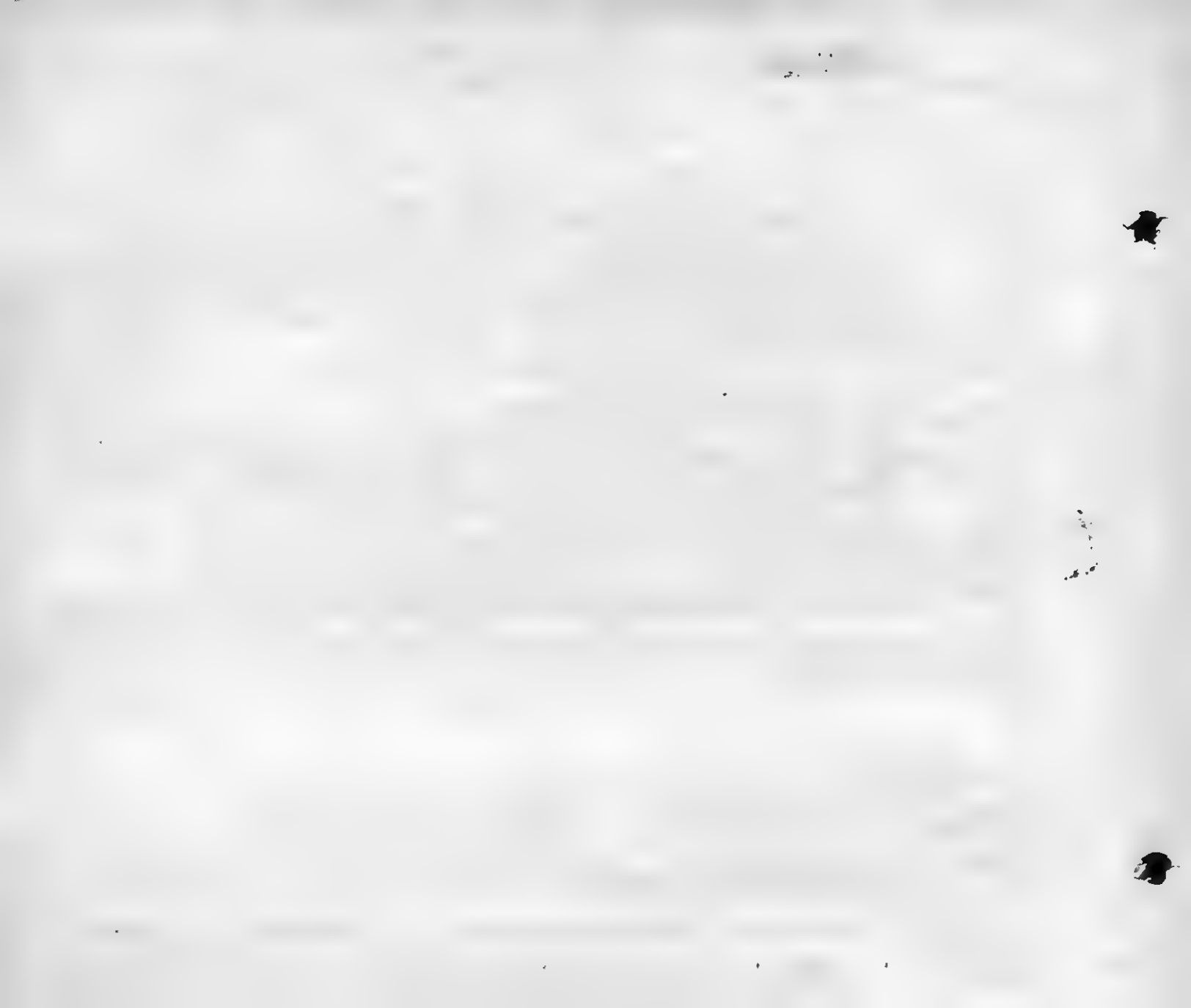
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10427

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10512

Item 7 Film 212-10-3-60-01

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 mo. 19 da.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>3900 14th St., N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Elizabeth</u> Last <u>Sale</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-11</u>
9. AGE (In years lost birthday) <u>49</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u> Hours <u>2</u> Min <u>3</u>	11. IF UNDER 24 HRS Hours <u>2</u> Min <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Trevor T. Hill</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5521</u>	
17. INFORMANT <u>Mrs. Mary T. Young - sister</u>		Address <u>Wash. D.C. 5521 Colo. Ave., N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>161X</u> DUE TO <u>Carcinoma of Pungnx + pharynx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>161X</u> DUE TO <u>Carcinoma of Pungnx + pharynx</u> (c) <u>161X</u> DUE TO <u>Carcinoma of Pungnx + pharynx</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>161X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1960</u> to <u>Sept 25, 1960</u> , that (I) (we) lost the deceased alive on <u>Sept 23, 1960</u> , and that death occurred <u>11:00 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>John Louzan</u>		22b. DATE SIGNED <u>Sept 26, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN LOUZAN</u>		22d. ADDRESS <u>6300 Columbia Blvd. S.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL BURIAL</u>		23b. DATE THEREOF <u>9/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>FREDERICK PURG. VA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Erley W. Thompson</u>		25a. REC'D BY REGISTRAR <u>SEP 27 '60</u>	
ADDRESS <u>1500 G. Street - N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Knease</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 filed 10-17-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

10544

13

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORRESPONDENCE, MD.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARILE REST HOME</u>				d. STREET ADDRESS <u>5711 KANS. AVE. N.W. (D.C.)</u>			
3. NAME OF DECEASED (Type or print) First <u>GEORGINA</u> Middle <u>B.</u> Last <u>SCHRAM</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>29</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1865</u> <u>OCT. 11/1865</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>UNK.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>GEORGE STEVENS</u>				14. MOTHER'S MAIDEN NAME <u>UNK.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>MARION E SCHRAM 5711 KANS. AVE D.C. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post-operative amputation for gangrene (L) leg</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>2 days</u> <u>1 month</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/27/1960</u> to <u>9/29/1960</u> , that I last saw the deceased alive on <u>9/28/60, 1960</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>10620 Georgia Ave. Silver Spring, Md.</u>							
DATE SIGNED <u>Arthur S. Hume</u>							
ACTUAL SIGNATURE <u>Donald Nelson</u>							
PHYSICIAN'S NAME (Type) <u>MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 1, 1960</u>		<u>Rock Creek Cemetery</u>		<u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Joy Co. 5406 Ill. ave. N.W.</u>				24a. REC'D BY REGISTRAR <u>OCT 4 '60</u>		24b. REGISTRAR'S SIGNATURE	

12

10545

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10514

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) b. STATE <u>Md</u> Pr. GEO. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing Home</u>		209 STREET ADDRESS <u>Sandy Spring Road</u>	
3 NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Tyler</u> Last <u>Sellers</u>		4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1960</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>August 24, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
10c. BIRTHPLACE (State or foreign country) <u>Pikeville Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William A. Sellers</u>		14. MOTHER'S MAIDEN NAME <u>Jane Coates</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17 INFORMANT <u>Mrs. Nelda Baugh, Laurel, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 177X DUE TO <u>C. A. Crossed</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ost. <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>8/14, 1960</u> to <u>9/7, 1960</u> that (I) (we) last saw the deceased alive on <u>9/7, 1960</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>B. P. Warren</u>		22b. DATE SIGNED <u>9/7</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>		22d. ADDRESS <u>Laurel Md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/9/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pikeville Md</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Sanderson, Laurel, Md</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10546

10515

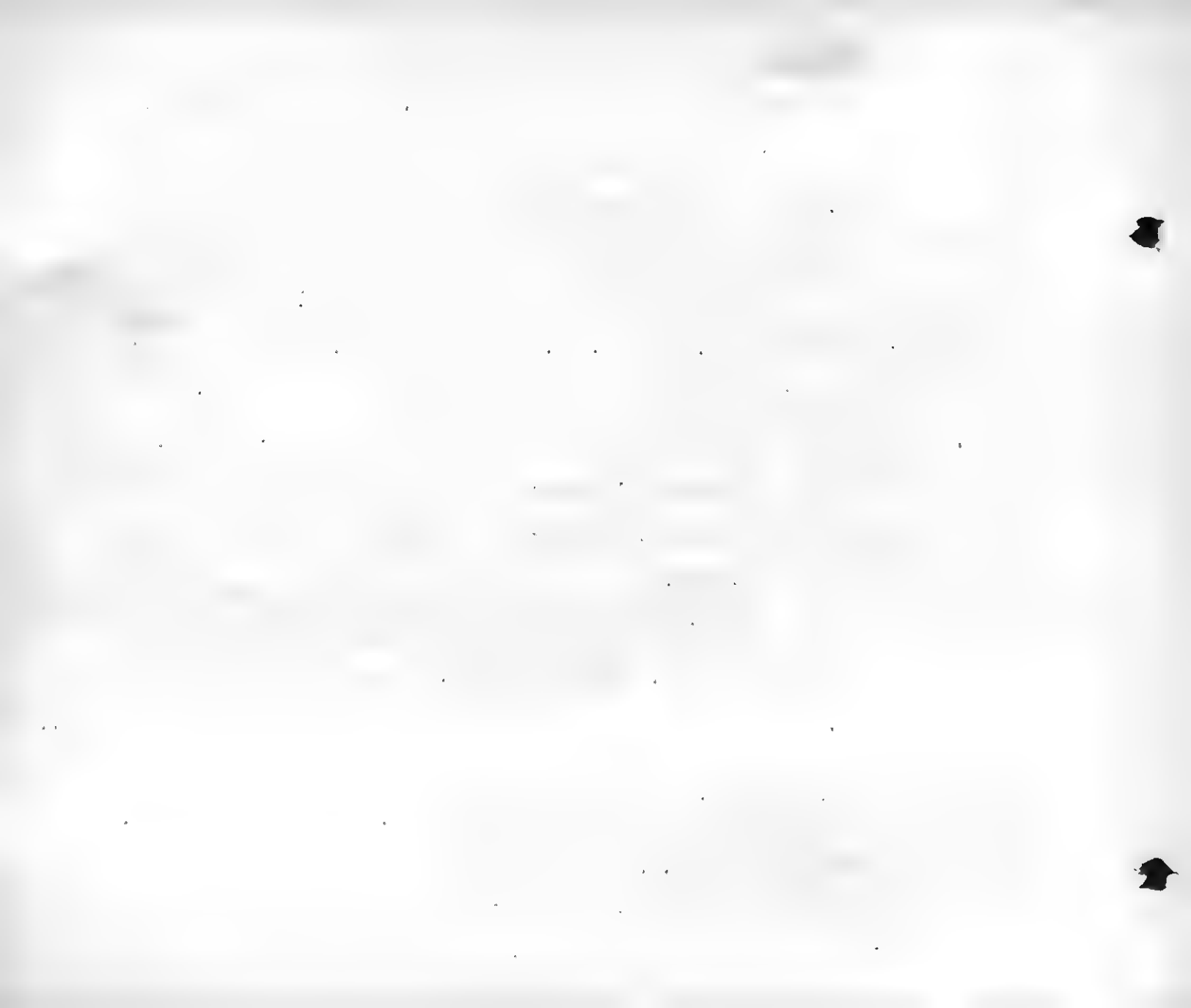
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7721 Beach Tree Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7721 Beach Tree Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Fanny Hollenman Semmer</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH <u>Sept 18 1960</u>	
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-15-1896</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stenographer retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ala</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.C</u>	
13. FATHER'S NAME <u>ERASMUS JASPER Hollenman</u> 14. MOTHER'S MAIDEN NAME <u>Sarah E. Allison</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>413-03-5541</u> 17. INFORMANT <u>Allison Semmer (son)</u> Address <u>Stu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <u>Frank J. Broschant</u> 22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>9/18/1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Chattanooga Mem. Park Chattanooga Tenn</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-18-60</u>	
23. FUNERAL DIRECTOR <u>Joseph Gauder's Sons 1756 Pa. Ave N.W.</u> 24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		24c. ADDRESS <u> </u> 24d. LOCATION (City, town, or country) (State) <u> </u>	

10441

CERTIFICATE OF DEATH

Reg. Dist. No. 10516

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburgh		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Pleasant Nursing Home		e. STREET ADDRESS 2100 University Blvd W	
3. NAME OF DECEASED (Type or print) First Edward Middle Benjamin Last Sewell		4. DATE OF DEATH Month Sept. Day 28 Year 60 19	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876 Sept 14, 1874
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Skilled Worker		10b. KIND OF BUSINESS OR INDUSTRY O. & P. Tel. Co.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Sewell		14. MOTHER'S MAIDEN NAME Carrie Magruder Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. cant find	
INFORMANT Elsie Sewell Horad		Address Wheaton, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorenal Failure, Anuria			
DUE TO (b) Arteriosclerosis Renal & cerebral			
DUE TO (c) Nephritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Concussion suffered 8/25/60 in fall from 2nd floor window. No fractures			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) At home. Mental confusion. Probably though cleaning windows	
20c. TIME OF INJURY Month, Day, Year 6:00 a.m. Aug. 25 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wheaton residence		20f. (City or town) to Freedmen's Hospital, D.C. (County) (State)	
21. I certify that I attended the deceased from May 31 , 19 60 to Sept. 28 , 19 60 , that I last saw the deceased alive on September 27, 1960 , and that death occurred at 4:14 A.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE Webster Sewell		ADDRESS (Street city or town, state) Norbeck Rt. 1 Silver Spring, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial	22b. DATE THEREOF 10/1/60	22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery.	22d. LOCATION (City town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surden		24a. REC'D BY REGISTRAR OCT 4 '60	24b. REGISTRAR'S SIGNATURE Charles S. Frank



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10409

10517

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE D.C. b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 6 weeks	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHEATON-SILVER SPRING NURSING HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
3 NAME OF DECEASED (Type or print) First ETHEL Middle THEODORA Last SHANE		4. DATE OF DEATH Month SEPTEMBER Day 22 Year 1960	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 31, 1890
9 AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect'y, Veterans Adm.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William Theodore Shane		14. MOTHER'S MAIDEN NAME Ella Yenney	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16 SOCIAL SECURITY NO none	
17 INFORMANT Mrs. Harold R. Northup, 4000 Mass. Ave., N.W.		Address Washington, D.C.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Exhaustion and cachexia 581.0 DUE TO (b) cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral thrombosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/49 19 to 9/22/60 19 that (I) (we) last saw the deceased alive on 9/21/60 19 and that death occurred at 7:30 from causes and on the date stated above.			
22a. SIGNATURE Horace H. Custis, Jr. MD		22b. DATE SIGNED 9/22/60	
22c. PHYSICIAN'S NAME (Type) Horace H. Custis, Jr. M. D.		22d. ADDRESS 1852 Columbia Rd, N. W. Washington 9, D. C.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/24/60	
23c NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24 FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Regional Co. Gaska		25a REC'D BY REGISTRAR DATE SEP 27 '60	
25b REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
M

10547

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10518

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE South Carolina b. COUNTY Greenville ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 101 Mount Vista Avenue	
3. NAME OF DECEASED (Type or print) First Bryan Middle Alan Last Shaw		4. DATE OF DEATH Month September Day 7 Year 1960	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 26, 1960
9 AGE (In years last birthday) yrs. 6 Months 10 Days 10 Hours 10 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Minor child)	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Bruce Shaw	
14. MOTHER'S MAIDEN NAME Barbara Williams		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 754.5 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 17, 1960 to September 7 1960 , that (I) (we) last saw the deceased alive on September 7 1960 , and that death occurred 3:50pm from the causes and on the date stated above			
22a. SIGNATURE Nina Starr Braunwald M.D.		22b. DATE SIGNED 9-8-60	
22c. PHYSICIAN'S NAME (Type) NINA STARR BRAUNWALD, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9-8-60		23b. DATE THEREOF 9-8-60	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Greenville, South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frame		25c. REGISTRAR'S SIGNATURE Arthur S. Frame	

9VVVVVVVXVV



CERTIFICATE OF DEATH

Reg. Dist. No.

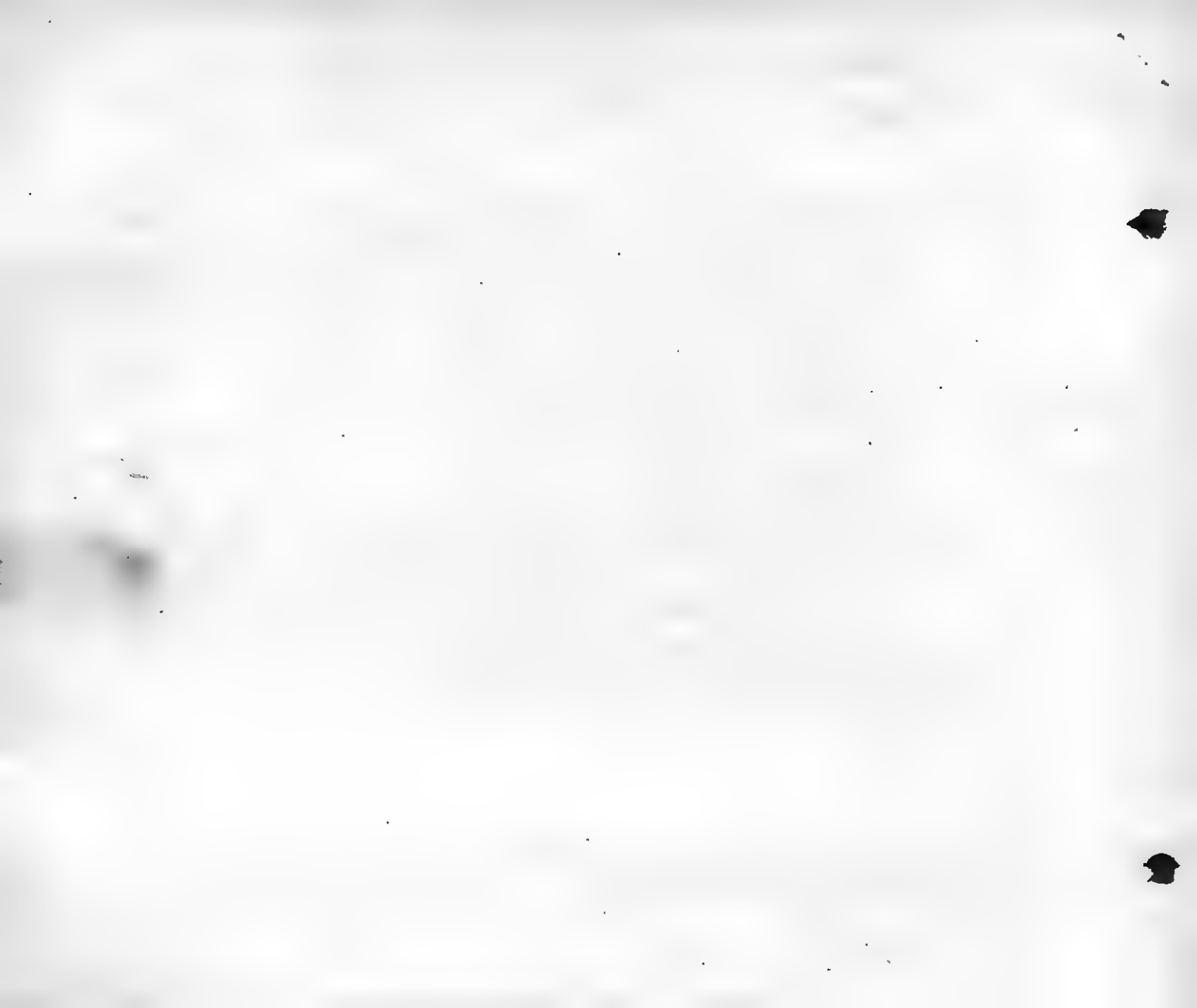
10428

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>627 Flower Avenue</u>				d. STREET ADDRESS <u>8027 Flower Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN VERNI SHEPHERD</u>				4. DATE OF DEATH Month Day Year <u>Sept. 9, 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/2/92</u>	
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Machinest</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>William Shepherd</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Brock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>1941-1945</u>				16. SOCIAL SECURITY NO. <u>570-31-6131</u>			
17. INFORMANT <u>Hilda G. Shepherd-Item # 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic carcinoma.</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>about a yr.</u> <u>about 2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>Sept 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 8</u> , 19 <u>60</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6300-13th St., N.W., Wash., D.C.</u> DATE SIGNED <u>9/6/60</u> ACTUAL SIGNATURE <u>Walter K. Angevine</u> M.D. <u>6300-13th St., N.W., Wash., D.C.</u> PHYSICIAN'S NAME (Type) <u>Wolte K. Angevine-6300-13th. St., N.W. Washington, D.C.</u>							
22a. BURIAL CREMATION OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter K. Angevine</u> ADDRESS <u>1381 E. Mntg. Ave., Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10429

10520

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 hrs.</u>		d. STREET ADDRESS <u>12207 Ken dall ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold George Shoffner</u>		4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-17</u>
9. AGE (In years lost birthday) <u>43</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative Calif. Packing Corp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Shoffner</u>		14. MOTHER'S MAIDEN NAME <u>Florence McDowell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW2 Army</u>		16. SOCIAL SECURITY NO. <u>173-01-8032</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>16 HRS.</u> <u>16 HRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 30</u> to <u>9/6</u> 19 <u>60</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9/5</u> 19 <u>60</u> , and that death occurred on <u>9/6</u> A.M. from the causes and on the date stated above			
22a. SIGNATURE <u>Harold Sterling</u> M.D.		22b. ADDRESS <u>1352 UNIVERSITY BLVD</u>	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>		22d. ADDRESS <u>1352 UNIVERSITY BLVD</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>TRANS. & BURIAL 9/10/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gulf Christian Church Cemetery, Gulf Mills, Pa.</u>	
23d. LOCATION (City, town, or county) (State)		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
24. FUNERAL DIRECTOR'S SIGNATURE - <u>WALTER E. PUMPHREY INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		25b. REG STRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
10430
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10521

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE _____ b. COUNTY <u>Y</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Gen-Hospital</u>		d. STREET ADDRESS <u>5121-4th St. N.E. Apt 105</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Mayr</u> First <u>SHUKIN</u> Middle <u>SHUKIN</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1960</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Jewish</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-1-92</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fruit Merchant (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) <u>Russia</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>Morris SHUKIN</u>		14 MOTHER'S MAIDEN NAME <u>Ethel Shukin</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17 INFORMANT <u>Son - old Record</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> (c) <u>Alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>9/7/1960</u> to <u>9/12/1960</u> that (I) (we) last saw the deceased alive on <u>Sept 12 1960</u> , and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) <u>Chas. H. Wolcott</u>		22d. ADDRESS <u>502 Woodward St NW</u>	
22b DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/13/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETH SHOLOM CEM</u>		23d. LOCATION (City, town or county) (State) <u>DC.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Goetting Funeral Home 4217-9th Ave</u>		25a. REC'D BY REGISTRAR <u>DATE SEP 14 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

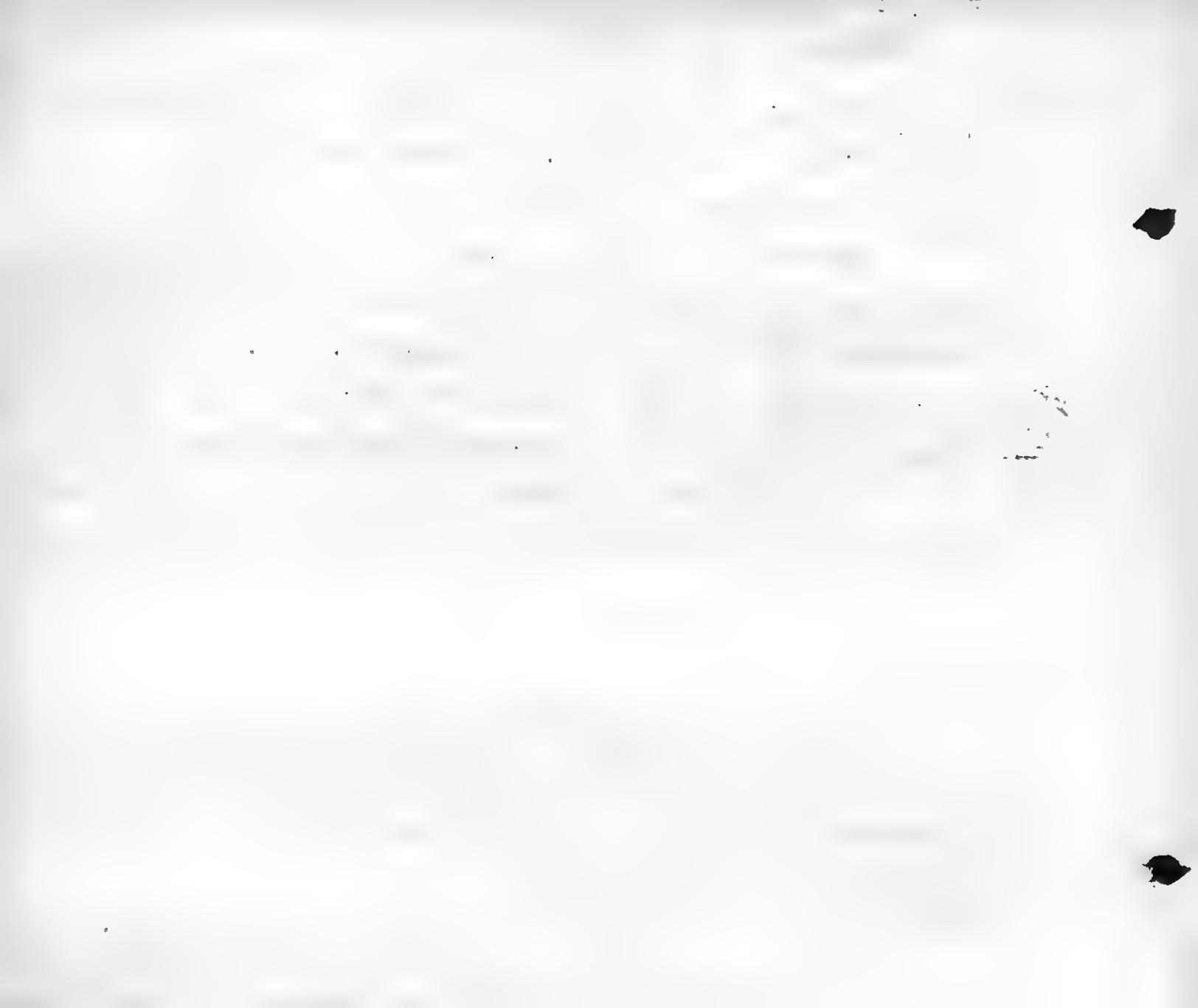
10548

Item 2 Filed 9-22-1960 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10522

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b 16 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander home of Rest		d. STREET ADDRESS 2032 Belmont Road, NW	
3. NAME OF DECEASED (Type or print) First Harriet Middle V Last Smoot		4. DATE OF DEATH Month Sept Day 24 Year 19 60	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 26-1901
9 AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 1 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Springville. N.Y.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Vedder		14. MOTHER'S MAIDEN NAME Altha Rust	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 	
INFORMANT Records-The Marylander home of Rest		Address # As 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 16, 1951 to September 24, 1960 that I last saw the deceased alive on September 22, 1960 , and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Bladensburg, Md.	
PHYSICIAN'S NAME (Type) 		DATE SIGNED 9/24/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-27-60	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Garton		24a. REC'D BY REGISTRAR SEP 28 '60	
ADDRESS 		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form-PH-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. (File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.)

VII. A15
5M 7/59

FOR STATE
HEALTH DEPT.

(M)

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10549 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10523

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5011 Greenway Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Soaper Stanley</u>		4. DATE OF DEATH <u>Sept 7 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney Lawyer</u>		11. BIRTHPLACE (State or foreign country) <u>Ky</u>	
13. FATHER'S NAME <u>A. O. Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Sue Bluffman Soaper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Louise T. Stanley (wife)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound thru skull</u> DUE TO (c)	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound thru skull</u>	
20c. TIME OF INJURY Month, Day, Year <u>2 in a.m. 9-7 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-7-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation 9/8/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon properly. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MD
10550
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10524

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB Since 1934	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4827 Montgomery Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Lucille Middle H Last Steed		4. DATE OF DEATH Month Sept. Day 27 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1897
9 AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months 9 Days 11	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY South Carolina	
11 BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME E. V. Hendrix		14. MOTHER'S MAIDEN NAME Lulla W. Willimon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Leon S. Steed, -Husband-same 2d		Address 	
18 CAUSE OF DEATH {Enter on any one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL FAILURE 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC PYELONEPHRITIS (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATOID ARTHRITIS		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from OCT. 1, 1958 to SEPT. 27, 1960 that (I) (we) last saw the deceased alive on 9/27/1960 , and that death occurred on 9/27/1960 from the causes and on the date stated above			
22a. SIGNATURE John H. Tuohy		22b. DATE SIGNED 9/27/60	
22c. PHYSICIAN'S NAME (Type) John H. Tuohy, M.D.		22d. ADDRESS 7720 Wisc. Ave. Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/60	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR SEP 29 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



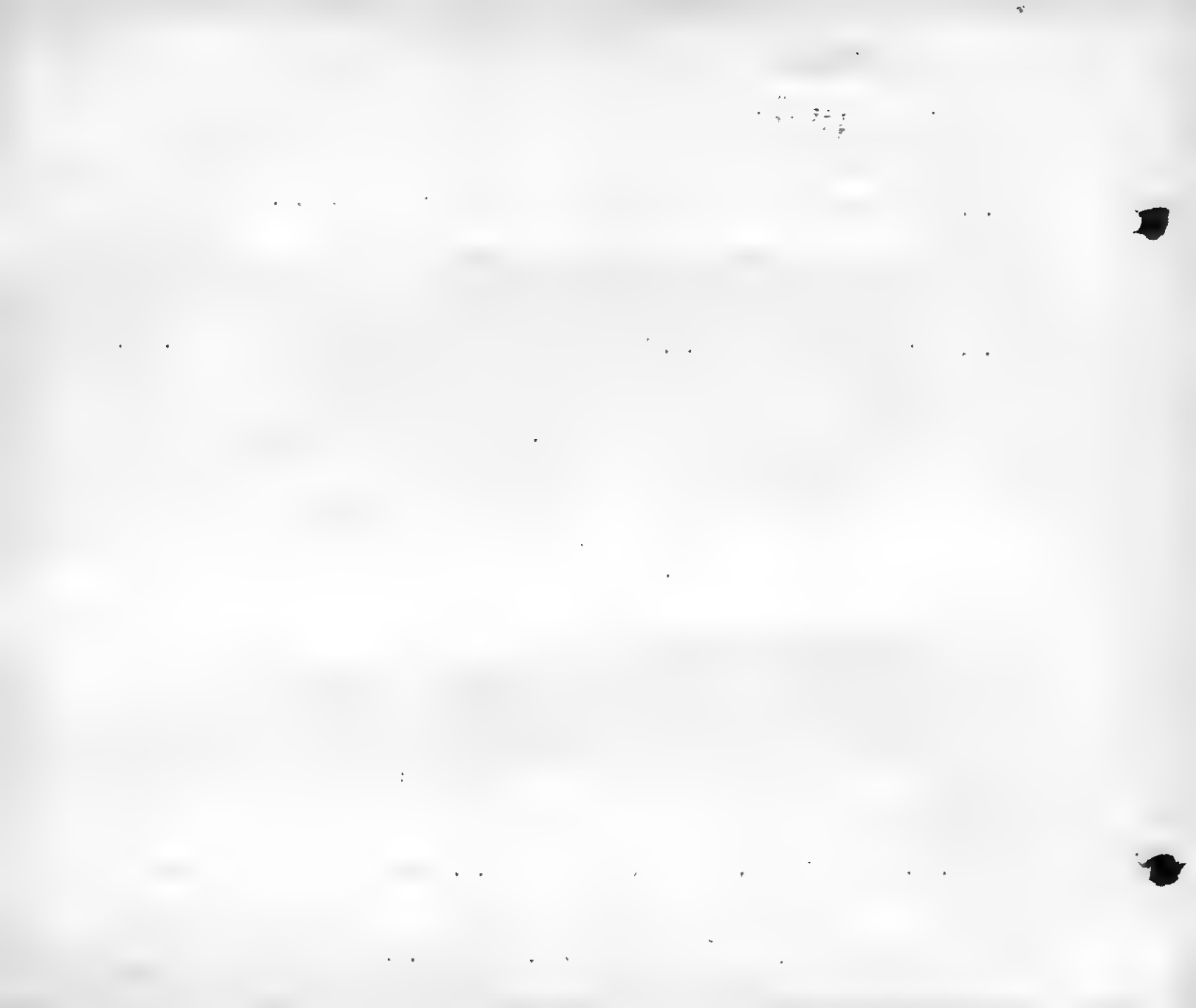
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

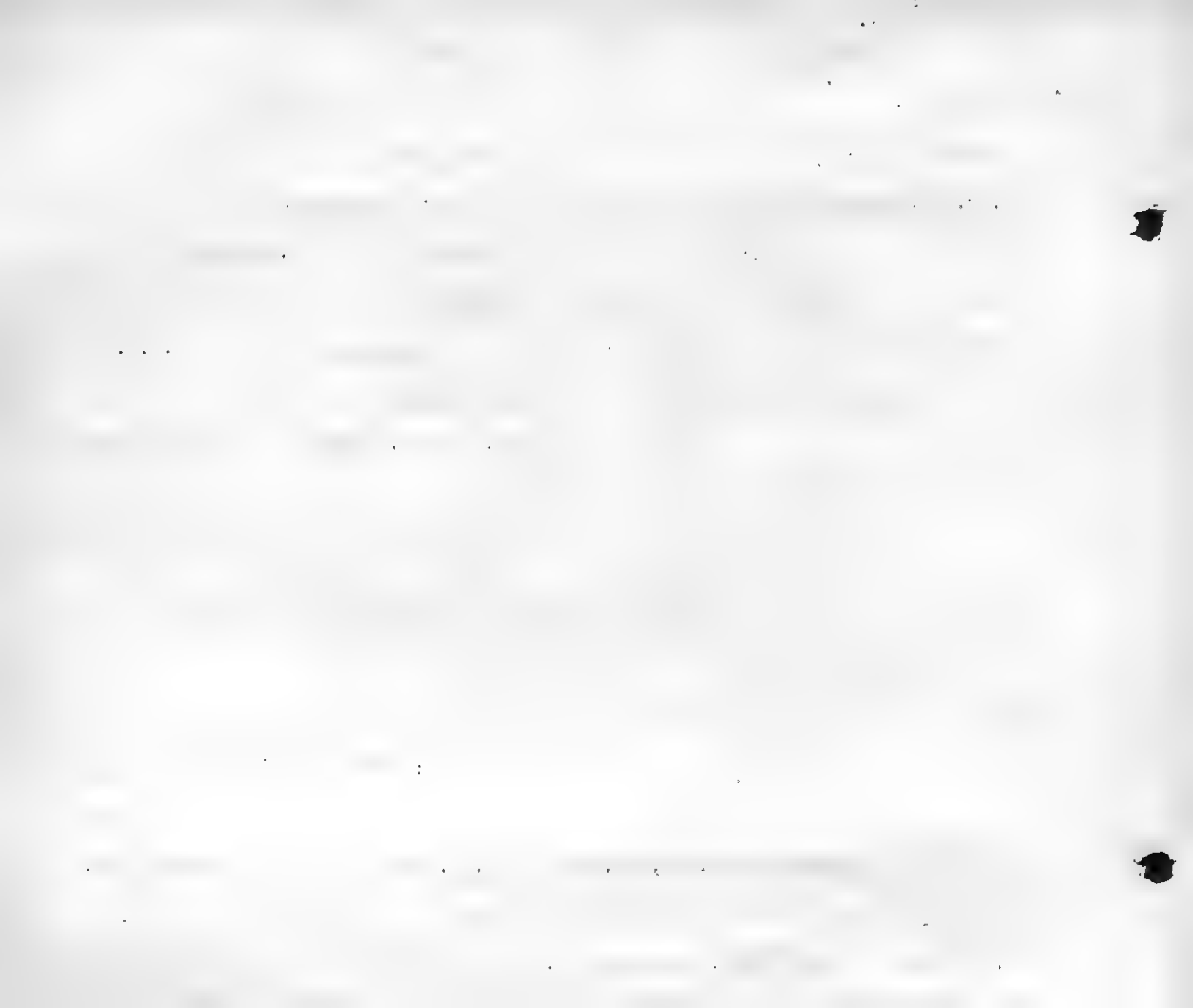
10525

10551

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY <input checked="" type="checkbox"/> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington c. STREET ADDRESS 250 Farragut St., N.W. d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Morris Middle (n) Last STEELE				4. DATE OF DEATH Month September Day 2 Year 1960					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-96		9. AGE (In years, last birthday) 64 yrs IF UNDER 1 YEAR: Months 64 Days 64 Hours 64 Min 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Steele				14. MOTHER'S MAIDEN NAME Frances ROBINSON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WWI & WWII		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Ella STEELE		Address Same as 2d			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis during surgery for abdominal aortic aneurysm DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 1 year								INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 8-11-1960 to 9-2-1960, that (I) (we) last saw the deceased alive on 9-2-1960, and that death occurred at 12:30 PM from the causes and on the date stated above.									
22a. SIGNATURE J. E. MC CLENATHAN				22b. PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-7-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME, 4812 Georgia Ave., N.W., Wash. D.C.				25a. REC'D BY REGISTRAR DATE SEP 7 '60		25b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

Reg. Dist. No.

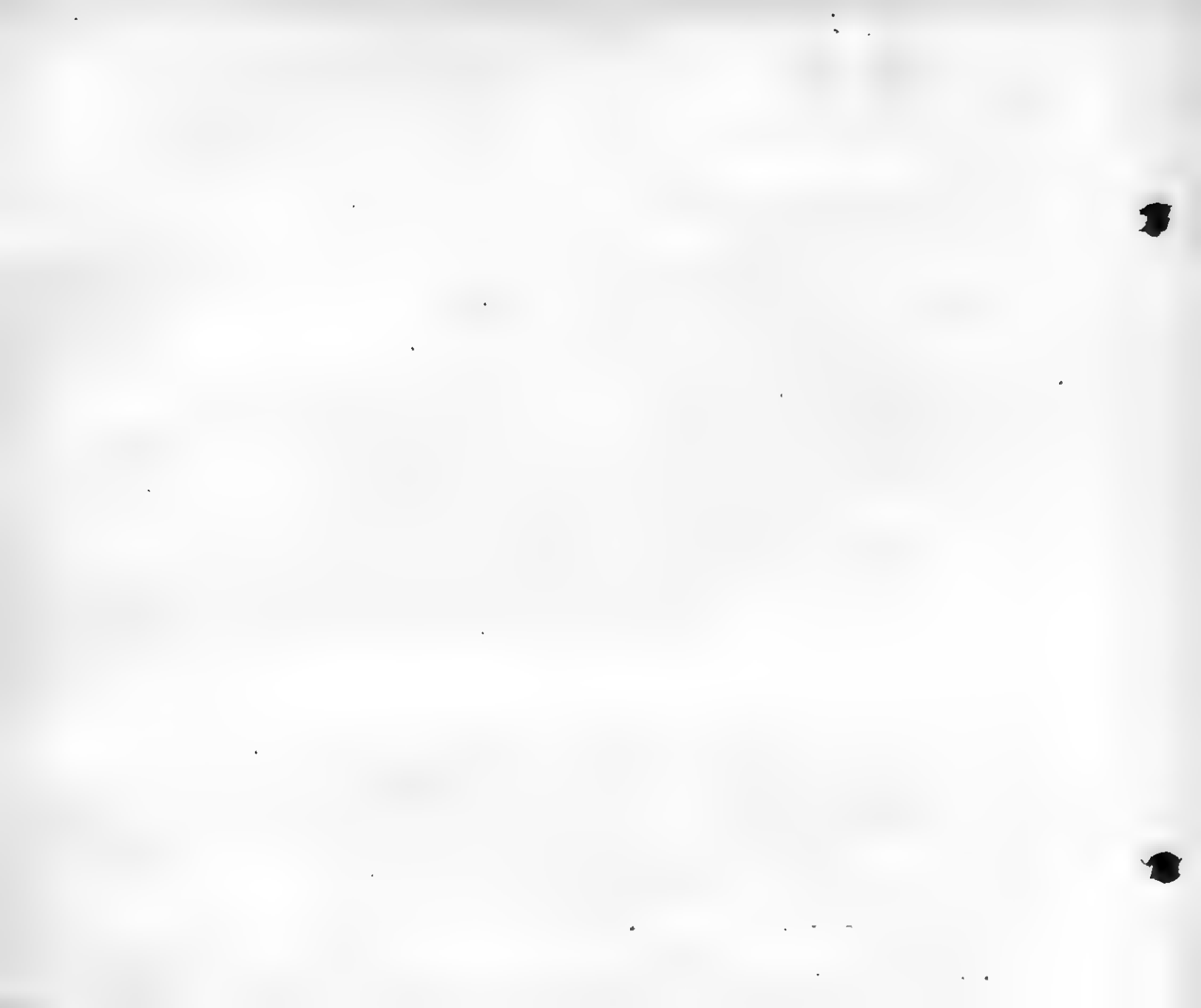
10527

10553

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 17 SOUTH IVORY ROAD	
3. NAME OF DECEASED (Type or print) First NETTIE Middle ELIZABETH Last SULLIVAN		4. DATE OF DEATH Month SEPTEMBER Day 10 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1880
9. AGE (In years lost birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN WILLIAM MUSGROVE		14. MOTHER'S MAIDEN NAME LOUISE GRIMES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis & uremia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8 , 19 47 , to Sept 10 , 19 60 , that I last saw the deceased alive on Sept. 10 , 19 60 , and that death occurred at 12 noon from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles S. Whitaker M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 9-10-60	
PHYSICIAN'S NAME (Type) C. S. WHITAKER M. D., CLARKSVILLE, MARYLAND			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-13-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	22d. LOCATION (City, town, or county) (State) Sunshine, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR SEP 14 '60	
24b. REGISTRAR'S SIGNATURE William L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

(1)

5

2

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6314 Bells Mill Rd. Suburban Hosp.				d. STREET ADDRESS 6314 Bells Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Omie		Middle L.		Last Terry		4. DATE OF DEATH Month Sept. 19, 1960	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/12/11	
9. AGE (In years last birthday) 18 yrs		10. IF UNDER 1 YEAR Months 10		11. IF UNDER 24 HRS Days 7		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Georgetown Hospital		11. BIRTHPLACE (State or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter C. Heath				14. MOTHER'S MAIDEN NAME Izza W. Flowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 579-09-0926		17. INFORMANT Mr. John Terry, step-son		Address 10110 Summit Ave., Kensington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Aspiration of Gastric Contents Sudden Sudden 29 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, Rt. femur.		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of car which struck tree		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 9/18/60 Hour, m. 5:48 P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Bethesda	
				(County) Montg.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/20/60	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE SEP 23 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10556

10530

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>16 days.</u>		d. STREET ADDRESS <u>5011 Lowell St. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur H. TEW</u>		4. DATE OF DEATH Month Day Year <u>9 26 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1875</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business man.</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Stationery</u>	
11c. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JCW</u>		14. MOTHER'S MAIDEN NAME <u>Buchanan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-07-1038</u>	
17. INFORMANT <u>Mrs. H. Wheeler</u>		Address <u>5011 Lowell St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic arterio sclerotic heart disease</u> DUE TO <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1 1960</u> to <u>Sept 26 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 24 1960</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above			
22a. SIGNATURE <u>E. H. Nicholas</u>		22b. ADDRESS <u>4830 - V St. N.E. Wash. D.C.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Humphrey</u>		22d. ADDRESS <u>Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/28/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>	23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 27 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>

7557 Wisconsin Ave Bethesda, Md

2000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10557

10551

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>296 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>437 Kennedy Street, NW, Apt. 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Theodore Thompson, Sr.</u>				4. DATE OF DEATH Month Day Year <u>September 24, 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>August 4, 1910</u>		9. AGE (In years last birthday) <u>50</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dealer in Meat</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Will Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> <u>1928 - 1931</u>		16. SOCIAL SECURITY NO. <u>577-09-9133</u>		17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Standstill</u>							<u>19 days</u> <u>39 months</u>
(b) <u>Anemia, Bacteremia, Inanition</u>							
(c) <u>Extensive Metastatic Carcinoma of Rectum</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 3, 1952</u> , to <u>Sept. 24, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 24, 1960</u> , and that death occurred <u>12:15 pm</u> from the causes and on the date stated above							
22a. SIGNATURE <u>George F. Miller, Jr.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9-25-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE F. MILLER, JR., M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Chambers</u>				ADDRESS <u>3072 M. St. N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 28 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

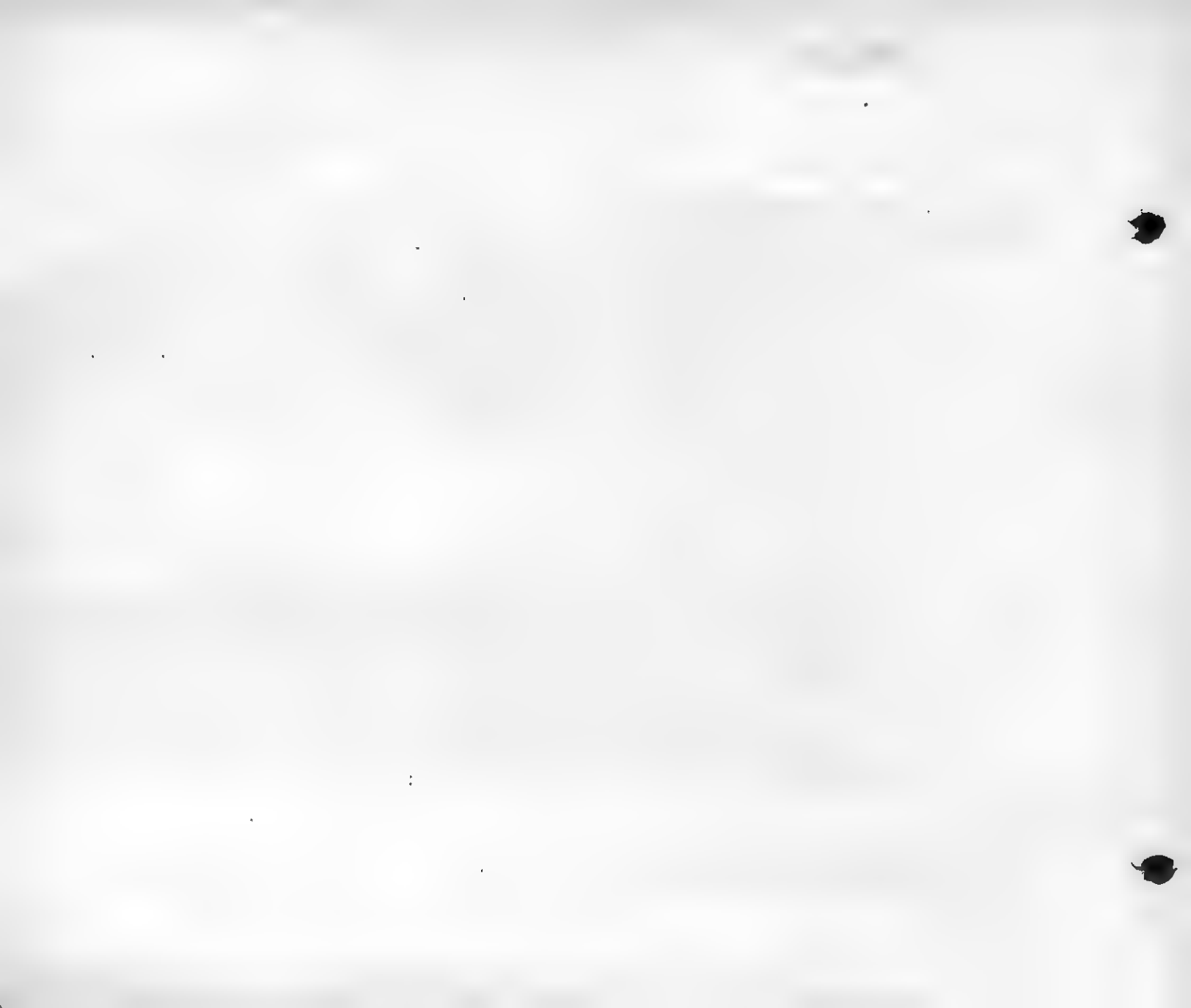
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10558

10552

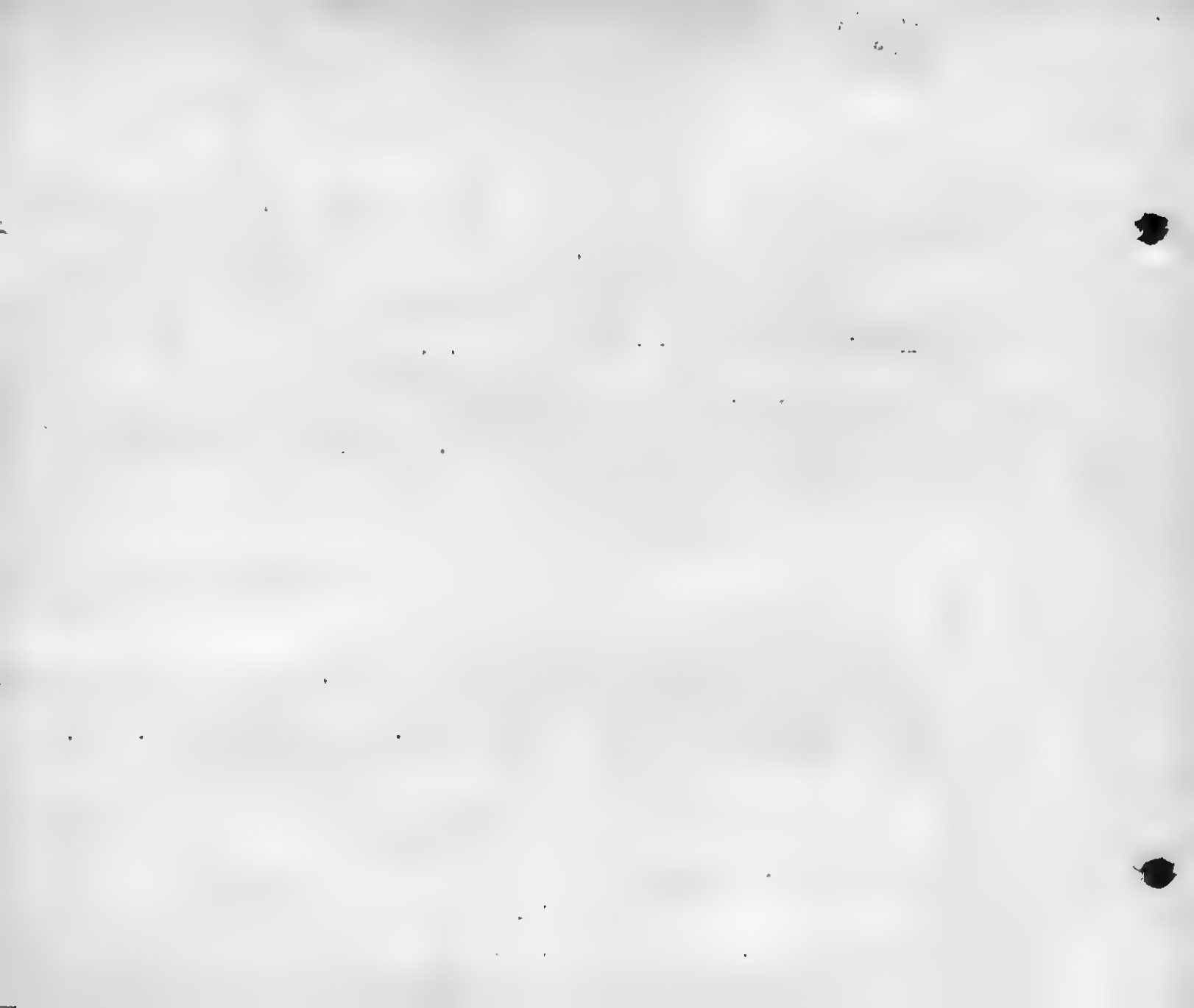
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY 2-2 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 100 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 147 Prince George Street			
3. NAME OF DECEASED (Type or print) First Ladeama Middle Beatrice Last THOMPSON				4. DATE OF DEATH Month September Day 4 Year 19 60			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-29 99	
9. AGE (In years last birthday) 61 yrs		IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min 0		IF UNDER 24 HRS Hours 1 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME John Gifford				14. MOTHER'S MAIDEN NAME Bertha Spencer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital records	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO 170X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Myocardial CH IN TERMINAL PHASE 1955-60 DUE TO Chronic Emphysema of the Lungs (c) 7 years				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 9-4				(County) 9-4			
(State) 19 60							
21. I certify that (I) (this hospital) attended the deceased from 5-27-60 to 9-4-60, that (I) (we) last saw the deceased alive on 9-4-60, and that death occurred at 3:55 PM on the causes and on the date stated above.							
22a. SIGNATURE John E. Knowles, LT, MC, USN				ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 9 6 60			
22c. PHYSICIAN'S NAME (Type) John E. Knowles, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9 8 60		23c. NAME OF CEMETERY OR CREMATORY U.S. National		23d. LOCATION (City, town, or county) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons, Annapolis, Md.				25a. REC'D BY REGISTRAR SEP 9 '60		25b. REGISTRAR'S SIGNATURE Charles S. Hume	



Arthur J. K...

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

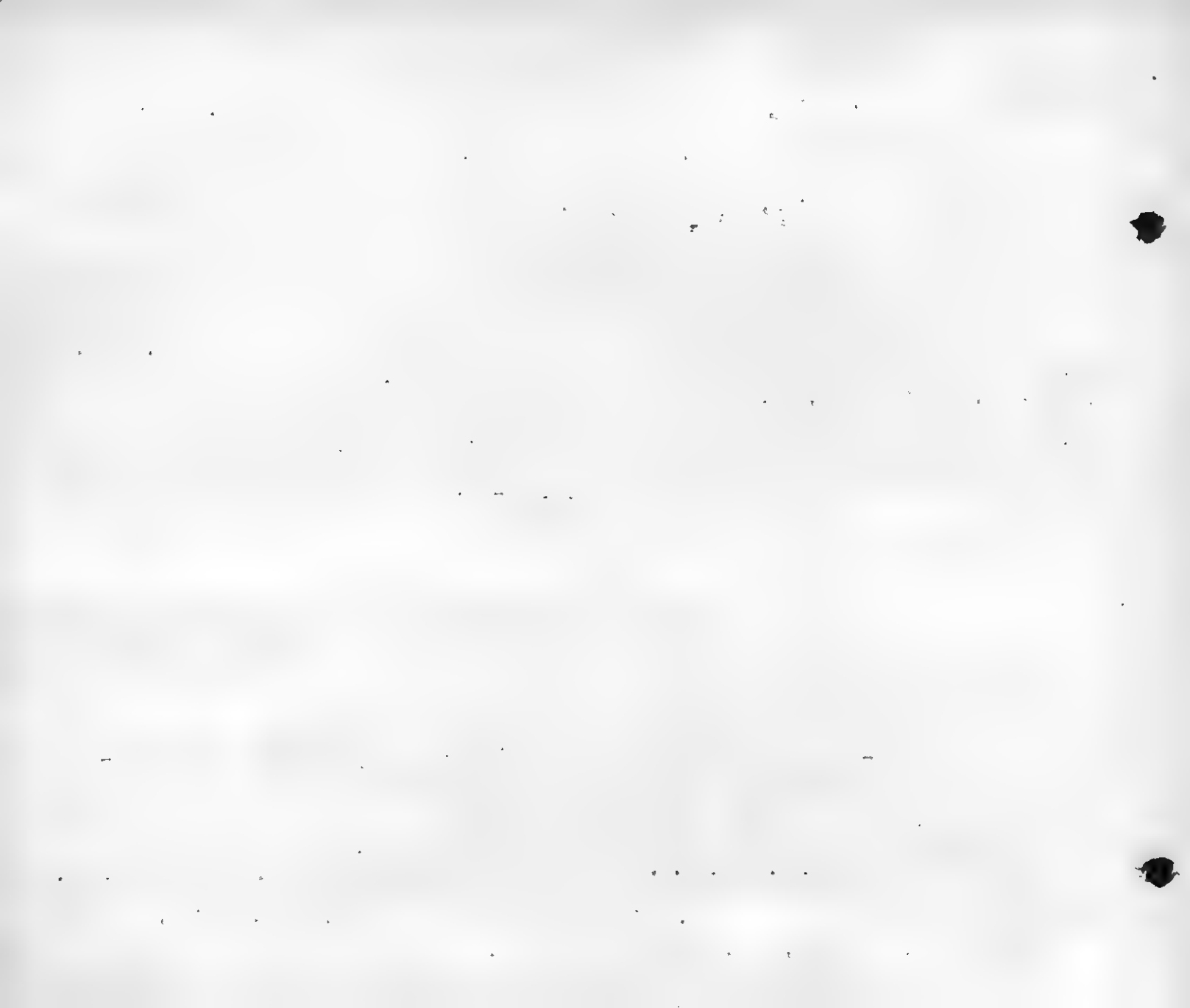
VR A15 (4)
15M 9/59

1
10560

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10534

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. STREET ADDRESS 4 Knox Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Albert Last Vere		4. DATE OF DEATH Month September Day 8 Year 19 60	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1955
9. AGE (In years last birthday) 5 yrs		IF UNDER 1 YEAR Months 5 Days 23 Hours 23 Min.	IF UNDER 24 HRS Hours 23 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Minor Child)		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME J. William Vere, Sr.		14. MOTHER'S MAIDEN NAME Gertrude Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tetralogy of Fallot - post operative DUE TO 754.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 years			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) September 4, 1960 September 8, 1960			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that (he) (this hospital) attended the deceased from September 4, 1960 to September 8, 1960 , that (he) (we) last saw the deceased alive on September 8, 1960 , and that death occurred at 2:08 PM from the causes and on the date stated above.			
22a. SIGNATURE William C. Awe M.D.		22b. DATE SIGNED 9/8/60	
22c. PHYSICIAN'S NAME (Type) William C. Awe, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 9/10/60	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur B. Hines			



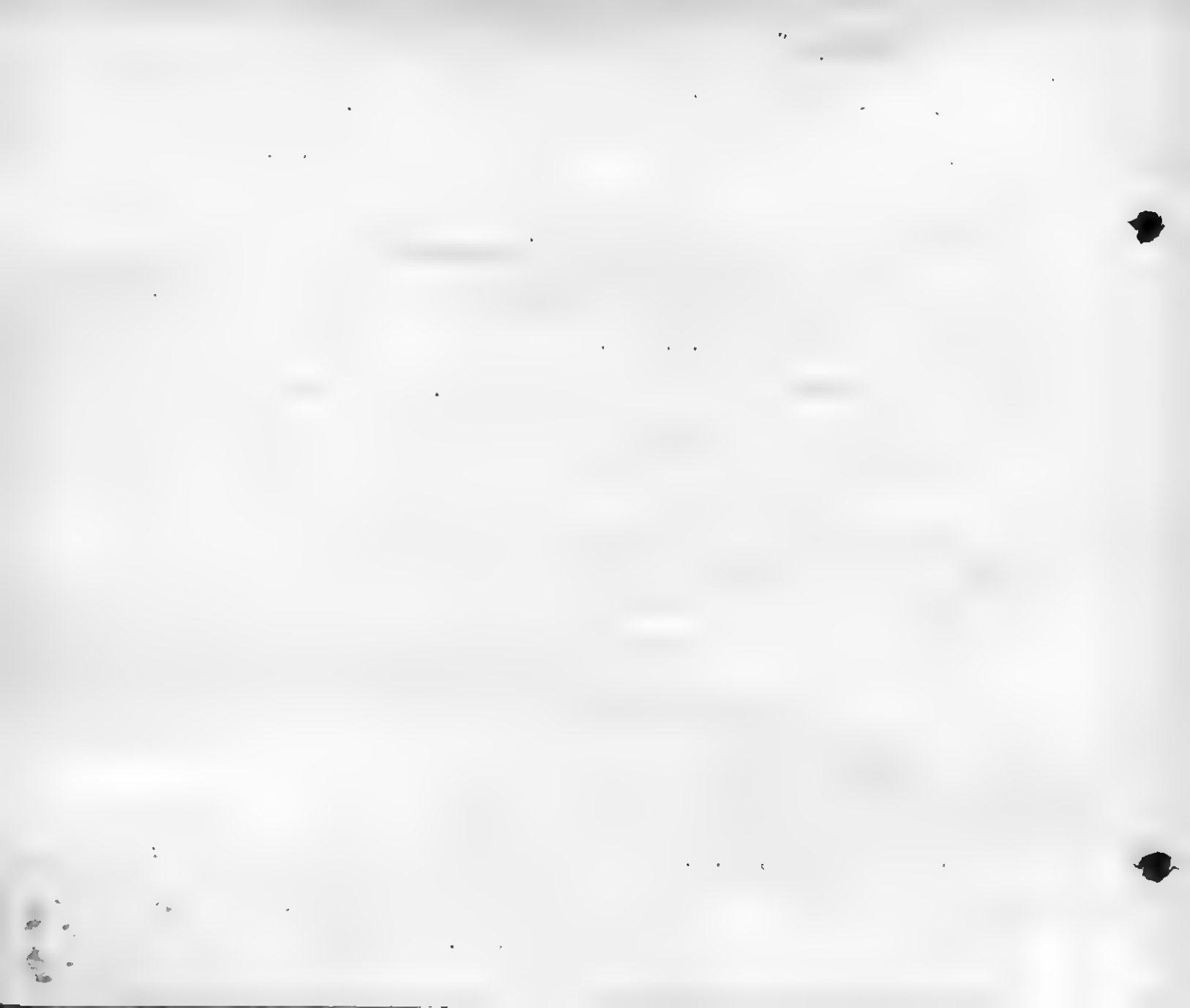
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10453
CERTIFICATE OF DEATH

10535

1. PLACE OF DEATH COUNTY <u>Montgomery</u> <u>Kensington Gardens San.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2019 Eye Street, N. W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>		d. STREET ADDRESS <u>1475</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Olive Van Wagenen</u>		4. DATE OF DEATH Month Day Year <u>9 11 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 30, 1879</u>
9. AGE (In years last birthday) yrs <u>81</u>		IF UNDER 1 YEAR Months Days <u>4 14</u>	IF UNDER 24 HRS Hours Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service Comm.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Y. State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John Van Wagenen</u>		14. MOTHER'S MAIDEN NAME <u>Jane E. Van Acken</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>S. C. LAKE</u>		Address <u>189 Highland Ave., N. Y. City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischaemic Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yk</u> <u>2 yk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>Sept 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 7, 1960</u> , and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u> M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE <u>9/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold, M. D.</u>		22d. ADDRESS <u>5041 Collesville Rd., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, or TRANSIT <u>Burial</u>		23b. DATE THEREOF <u>9/12/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Poughkeepsie Rural Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Poughkeepsie New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. A. Murphy</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>SEP 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10410

10536

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before adm ssion) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Sanitarium		e. STREET ADDRESS 15500 Justice Road	
3. NAME OF DECEASED (Type or print) First Harry Middle E Last Warner		4. DATE OF DEATH Month Sept. Day 19 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1881
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 10 Days 28 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Massachusetts	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Elmer Warner		14. MOTHER'S MAIDEN NAME Clara Hager	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Ina L. Warner-wife-same 2d	
17. INFORMANT Ina L. Warner-wife-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Failure 177X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral metastasis DUE TO (c) Carcinoma of Prostate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hours 6 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-12-1960 to 9-11-1960 that (I) (we) last saw the deceased alive on 7-19-1960 , and that death occurred at M, from the causes and on the date stated above			
22a. SIGNATURE Edward J. Richards M.D.		22b. DATE SIGNED 9/20/60	
22c. PHYSICIAN'S NAME (Type) Edward J. Richards		22d. ADDRESS 10110 Geo. Ave. Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit 9/23/60		23b. DATE THEREOF 9/23/60	
23c. NAME OF CEMETERY OR CREMATORY North Beverly Cemetery		23d. LOCATION (City, town, or county) (State) Beverly, Mass.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE SEP 22 '60		25c. REGISTRAR'S SIGNATURE Clifton L. Pumphrey	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10557

10454

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>21111</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDEN SAN.</u>		d. STREET ADDRESS <u>618-WEST NORTH AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE BLANCHE WATCHMAN</u>		4. DATE OF DEATH Month Day Year <u>SEPT 10 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17 - 1884</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Carimatus Jelks</u>	
14. MOTHER'S MAIDEN NAME <u>suburban</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	
16. SOCIAL SECURITY NO		17. INFORMANT <u>E. J. Duncan 7206 - Arbutus St. Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure, acute</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Dehydration</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10:58 to Sep 9 1960</u> that (I) (we) last saw the deceased alive on <u>Sep 9 1960</u> and that death occurred at <u>9:50 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibodeau</u>		22b. DATE SIGNED <u>Sep 10/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBODEAU</u>		22d. ADDRESS <u>16609 Concord Ave Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 12-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Int. Mount Carmel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROS.</u>		25. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
26. FUNERAL DIRECTOR'S ADDRESS <u>1661 9th St. N.E. D.C.</u>		26. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

12/1/2011
12/1/2011

12/1/2011
12/1/2011

CERTIFICATE OF DEATH

Reg. Dist. No.

10561

10538

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG			
c. LENGTH OF STAY IN 1b 6 DAYS				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS Box 171			
3. NAME OF DECEASED (Type or print) First OLIVE Middle MYERS Last WATERS				4. DATE OF DEATH Month SEPT. Day 14 Year 19 60			
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/99		9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME KIRK GRIFFITH				14. MOTHER'S MAIDEN NAME MINNIE RIGGS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		INFORMANT HOSPITAL RECORDS, Address OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvulitis, Chronic, due to Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Not Known. (c) Not Known.							INTERVAL BETWEEN ONSET AND DEATH Not Known.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to Sept. 14, 1960 , that I last saw the deceased alive on Sept. 13, 1960 , and that death occurred at 5:45 M. from the causes and on the date stated above.							DATE SIGNED 9/14/60
ACTUAL SIGNATURE Jack Schumacher M.D.				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.				GAITHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-60		22c. NAME OF CEMETERY OR CREMATORY Neelsville		22d. LOCATION (City, town, or county) (State) Germantown, RED, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.				24a. RECEIVED BY REGISTRAR SEP 16 60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10562

10553

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MARYLAND</u>	
c. LENGTH OF STAY N 1b <u>11/24/59-9/3/60</u>		d. STREET ADDRESS <u>6206 DAHLONEGA RD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Watson</u> Last <u>Watson</u>		4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/1893</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u>	11. IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INTERIOR DECORATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Decorating</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Watson</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Patrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>202-05-6643</u>	
17. INFORMANT <u>Niece</u>		Address <u>Wash. 16, D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>Diabetes mellitus</u> DUE TO <u>Generalized arteriosclerosis</u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>Nov 24, 1959</u> to <u>Sept. 3, 1960</u> that I last saw the deceased alive on <u>Aug 31, 1960</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		DATE SIGNED <u>9/3/60</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		ADDRESS <u>1019 University Boulevard Silver Spring Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/8/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bordentown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bordentown, New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1947 JAN 10 MON

BETHEDA HARBOR

2000 LANTANA RD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10411

10540

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>1 YEAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JOHNSON'S NURSING HOME</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE, MARYLAND</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>JOHN</u> Last <u>WEBER</u>		d. STREET ADDRESS <u>8415 NEW HAMPSHIRE AVE.</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 20, 1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINER (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MINING (coal)</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WM. WEBER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. BEULAH MC HOCKO</u>		Address <u>8415 NEW HAMPSHIRE HYATTSVILLE, MD AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE BRONCHIAL ASTHMA</u> <u>24 HRS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY EMPHYSEMA</u> DUE TO (c) <u>PULMONARY FIBROSIS</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERAL AND CEREBRAL ATHEROSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS.</u> <u>79 RS.</u> <u>104 RS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 11, 1956</u> to <u>Sept. 30, 1960</u> that (I) (we) last saw the deceased alive on <u>Sept. 30, 1960</u> and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>James A. Roberts</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <u>9/30/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		22d. ADDRESS <u>8907 Georgia Ave. Silver Spring, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>10/3/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hollisterville Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hollisterville, Lackawanna Co. Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WANNER E. PUMPHREY, INC.</u> <u>Raymond E. Jones</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 3 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>			





TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

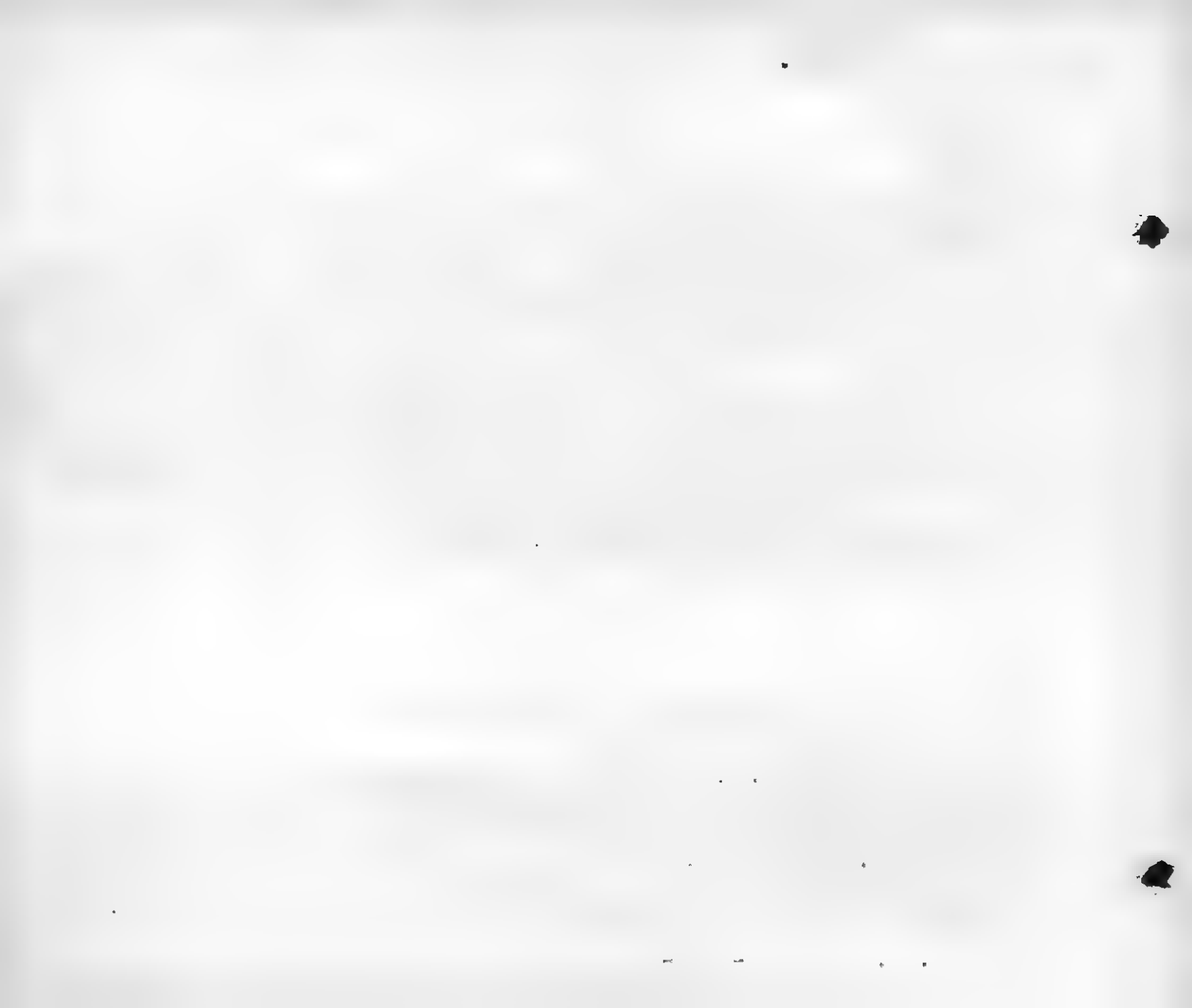
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10563

10542

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE West Virginia b. COUNTY Yolyn c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X d. STREET ADDRESS (No street address) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Deborah Carolyn White		4. DATE OF DEATH Month Day Year September 28, 19 60	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 17, 1951
9 AGE (In years last birthday) 9 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William White	
14. MOTHER'S MAIDEN NAME Estelle Cartin		15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Staphylococcal septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphatic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) 19
20f. (City or town) 19		(County) (State)	
21 I certify that (I) (this hospital) attended the deceased from August 26, 1960 to September 28, 1960 , that (I) (we) last saw the deceased alive on Sept. 28, 1960 and that death occurred 10:15 AM from the causes and on the date stated above			
22a SIGNATURE W. Walter Oppelt M.D.		22b. DATE SIGNED 9/28/60	
22c PHYSICIAN'S NAME (Type) W. Walter Oppelt, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal	23b DATE THEREOF 9/29/60	23c NAME OF CEMETERY OR CREMATORY Highland Mem Gardens	23d LOCATION (City, town, or county) (State) Logan West Virginia
24 FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co-2901-14th St NW DC		25a REC'D BY REGISTRAR DATE SEP 30 1960	
25b REGISTRAR'S SIGNATURE Charles E. Hines			



CERTIFICATE OF DEATH

Reg. Dist. No.

10431

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lackawanna Senior Hosp</u>		d. STREET ADDRESS <u>9401-16th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Mae Williams</u>		4. DATE OF DEATH <u>September 16 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 7, 1901</u>
9. AGE (In years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Charles T. Scip</u>	
14. MOTHER'S MAIDEN NAME <u>Grace Sickler</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>yes</u>		17. INFORMANT <u>Washington Sen & Hosp. Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with Metastases</u> 1063a DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>3-11-60</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 15</u> 1958 to <u>Sept 16</u> 1960, that I last saw the deceased alive on <u>Sept 15</u> 1960, and that death occurred at <u>1:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock, M.D.</u>		ADDRESS (Street, city or town, state) <u>7717 Carroll Ave</u> DATE SIGNED <u>9-16-60</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock, M. D.</u>		<u>Takoma Park 12 11 12</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>TRANSIT & BURIAL</u>	<u>9/20/60</u>	<u>Valley View Cemetery</u>	<u>Lackawanna County, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner & Son, Inc.</u>		24a. REC'D BY REGISTRAR <u>SILVER SPRING, MD.</u> DATE <u>SEP 19 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOLD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

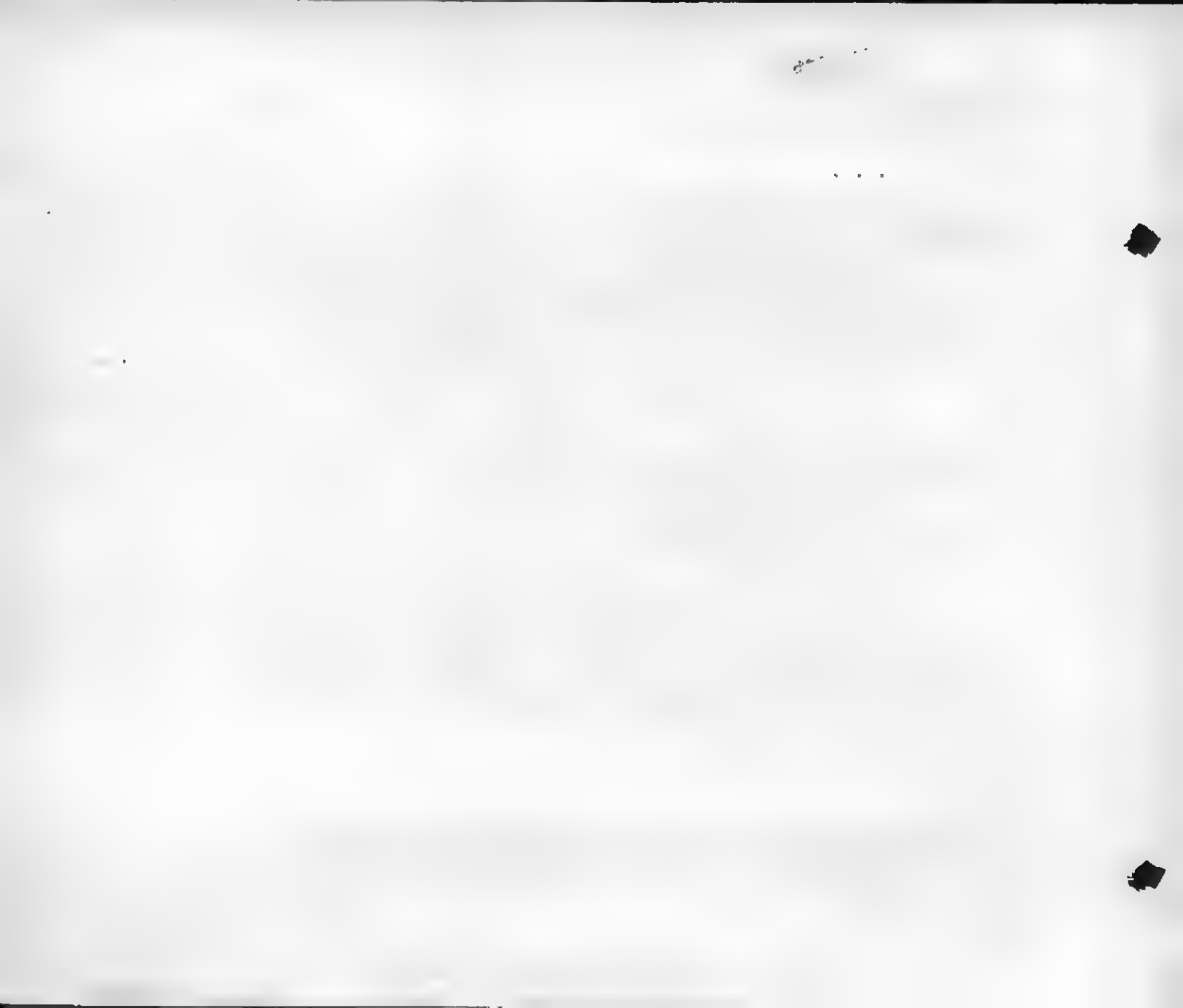
CERTIFICATE OF DEATH

10544

10564

Item 7 Film 11 4-20-60

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN TB Derwood R.F.D. #1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armstrong Nursing Home		d. STREET ADDRESS River Road.,	
3. NAME OF DECEASED (Type or print) First Edward Middle Wilmore Last Wilmore		4. DATE OF DEATH Month Sept Day 8 Year 1960	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1878
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 8 Days 8 Hours 19 Min 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Eastern Shore, Md	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Nursing Home Records		Address Nursing Home Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 422-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis. DUE TO (c) Chronic Myocarditis.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1960 to 9/8 1960 that (I) (we) last saw the deceased alive on Sept 7 1960 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Luciano L. Leal		22b. DATE SIGNED SEP 13 '60	
22c. PHYSICIAN'S NAME (Type) Luciano L. Leal M.D.		22d. ADDRESS Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/60	
23c. NAME OF CEMETERY OR CREMATORY County Home		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		25a. REC'D BY REGISTRAR SEP 13 '60	
25b. REGISTRAR'S SIGNATURE Robert L. Snowden		25c. ADDRESS Rockville, Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information obtained by the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 3 and 4 should be filled with the information obtained by the funeral director. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information obtained by the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 3 and 4 should be filled with the information obtained by the funeral director.

VR A15 (4)
ISM 9/59

10458

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10545

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>see below</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. Kenesaw Apts.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chestnut Lodge, Inc.</u>		d. STREET ADDRESS <u>16th and Irving St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Flor</u> Middle <u>Street</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/15/80</u>
9. AGE (In years, last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife-teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none(school)</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel B. Street</u>		14. MOTHER'S MAIDEN NAME <u>Susan Emily Gullett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Chestnut Lodge, Inc. Rockville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, right upper lobe, lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic peptic ulceration, first portion of duodenum - hemorrhage</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>9-10</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9-9</u> , 19 <u>60</u> , and that death occurred on <u>9-10</u> , 19 <u>60</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Corinne Cooper</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u>		22d. ADDRESS <u>Rockville, Md. 104 S. Washington St.,</u>	
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> <u>Burial</u>		23b. DATE THEREOF <u>9/12/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SH. Harris Co</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

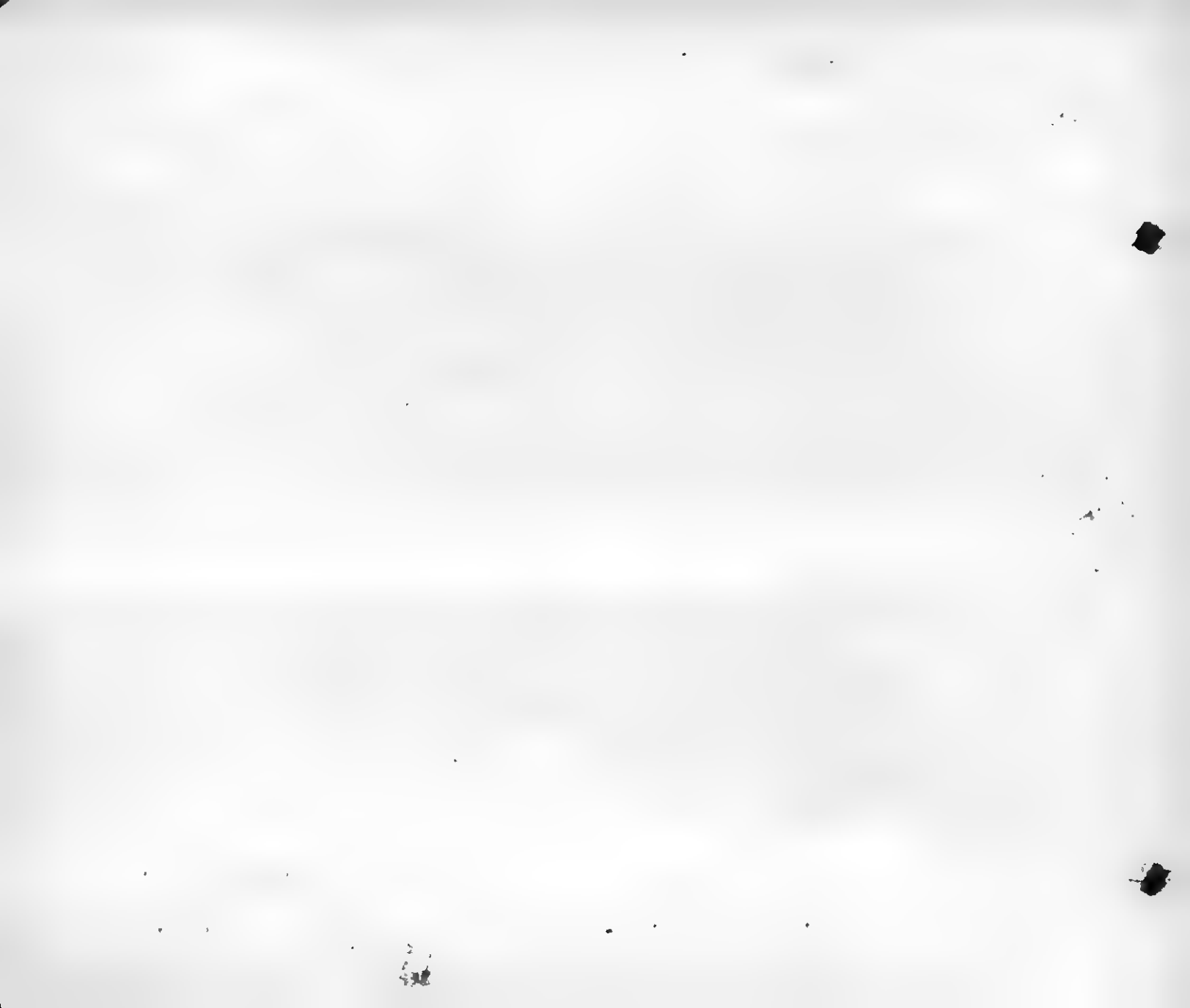
10565

10546

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>14528 Fairfield Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norton Ordic Wing</u>		4. DATE OF DEATH Month Day Year <u>September 25 19 60</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/18/84</u>
9. AGE (In years lost birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Monroeville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Wing</u>		14. MOTHER'S MAIDEN NAME <u>Abigail Newton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son Roger Wing</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Cirrhosis</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1943</u> , 19 <u>43</u> to <u>9-25</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>9-25</u> , 19 <u>60</u> and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul D. Cantor</u>		22b. DATE SIGNED <u>9-25</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul D. Cantor</u>		22d. ADDRESS <u>1709 Montgomery La. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 28, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg Rd. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chry Chas Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 29 '60</u>	
ADDRESS <u>5103 Wisconsin Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>	

M

I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10566

10547

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>14105 Canterbury Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Page Robt Wotring</u>		4. DATE OF DEATH Month Day Year <u>Sept 5 19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1892</u> yrs. <u>78</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Wotring</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Shuttleworth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-38-6114</u>	
17. INFORMANT <u>Agnos Wotring / same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 584X DUE TO (b) <u>Thrombosis, Hepatic + Portal Veins</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Obstruction, Common Bile duct by calculi with cholangitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 30</u> 19 <u>60</u> , to <u>Sept 5</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9-5</u> 19 <u>60</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J.P. McCarrick</u> M.D.		22b. DATE SIGNED <u>9-5-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.P. McCARRICK M.D.</u>		22d. ADDRESS <u>509 Viers Mill Rd. Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/8/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Terra Alta, W. Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 9 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

10-01

OFFICE OF THE

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10548

10567

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4115 Tulare Drive			
3. NAME OF DECEASED (Type or print) First George Middle Louis Last Yazge				4. DATE OF DEATH Month September Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1960		9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 8 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Raymond Yazge				14. MOTHER'S M maiden name M. Miriam Bashoor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Escherichiacoli septicemia DUE TO (c) Staphylococcal Enterocolitis							INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days 5-6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diffuse hepatic tumor							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 	Month Day Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (M) (this hospital) attended the deceased from September 1, 1960 to September 15, 1960 that (M) (we) lost saw the deceased alive on September 15, 1960 , and that death occurred on 8:54 AM from the causes and on the date stated above.							
22a. SIGNATURE Orlando Wesley McBride				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/15/60	
22c. PHYSICIAN'S NAME (Type) Orlando Wesley McBride, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/17/60		23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE SEP 19 1960	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

9VVVVVVVV XVV

TABLE

10

